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MENTAL HYGIENE

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CHARACTER DEVELOPMENT IN NURSERY SCHOOL

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THIS paper is based on observations and discussions that were part of a seminar for teachers of young children. The common denominator of the three topics dealt with—"Tattling," "Segregation According to Age," and "Siblings in School"—is the child's *spontaneous* endeavor to come nearer to adult status and standards. These early efforts are by no means clearly labeled as reasonable or altruistic. It takes an understanding eye to detect, for instance, in tattling, boasting, or bossing the seeds of constructive ego developments.

Psychoanalytic insight not only can help in the treatment of the child who is maladjusted; it has a great deal to offer in the case of the average well-adjusted child. In certain aspects of education, psychoanalytical insight can carry on where progressive education leaves off—or, rather, left off, one or two decades ago. Let us look at the main conceptual tools of progressive education: an attitude of permissiveness toward the young child; consideration of his play interests and concerns as important; the postponement of academic learnings and exacting skills in such a way as to shield the child from frustration, failures, and experiences of inadequacy. In short, the so-called progressives declare a kind of educational moratorium: all pressures should be removed from the young child. This is an excellent beginning, but it is not enough.

The psychoanalytical educator, too, is lenient. However, he sees beyond the gratification of early instinctual needs. *He is lenient in order to win as his ally the full force of the child's*

own wish to grow up. As little as possible of the energy of this precious wish should be dissipated in fighting the adult. A severe, suppressive education is as wasteful as one whose only tool is indulgence. The more the child is understood, encouraged, and supported in *his* efforts to grow up, the more external pressure can be reduced.

"TATTLING"

In nursery school, children occasionally come to the teacher to "tattle" about another child. Some report an injustice done to them, but others relate incidents in which they themselves were not involved. Sometimes a child seems to have one main concern in life—to detect all the wrong things anybody ever does and to report them with a portentous air. That the teacher pays little or no attention to these tales does not seem to cool off the child's zeal; he goes on reporting the most trifling infractions of law and custom.

There is still another kind of tattling. In a group of five-year-olds, there may be a youngster who instigates a playmate to do something that is forbidden and then rushes over to the teacher to report the misdeed.

In a progressive school, tattling is discouraged. Teachers have various techniques for doing this and get rather baffled and annoyed with the child who persists in what they consider antisocial behavior. A few examples quoted verbatim from the teachers' notes will be given:

> Lois, aged four and a half: "Teacher, Charles did it again. The bathroom is all wet."
>
> Teacher, calmly: "Did Charles do that? What would Lois like to do? Wash the paintbrushes?"
>
> Peter: "Miss W., Nolan hit Sheldon!"
>
> Teacher: "Did he? I suppose if Sheldon is hurt, he will come and tell me about it."
>
> Mary: "Miss Estelle, you know what? Joe threw down all the blocks, and he is going to throw down some more."
>
> Teacher: "Thank you, Mary. I'll go over there later. I'm too busy now."
>
> I find that ignoring tattling has helped a great deal and has made her realize that she gains nothing by telling on the others. If she does report something that needs correction, I take up the incident later, or in a manner in which she gains no satisfaction.

D, aged five, is mostly a spectator in the park and does not participate in the vigorous physical activities of the other children. He comes frequently to the teacher and tattles: "The children have all run up on the rocks."

Teacher: "We don't tell on each other. We play nicely together."

Arthur, four and a half, tattles about anything and everything. He is constantly running to the teacher. He begins this way: "Frances, do you know what? . . ."

I usually stop him by saying, "Do you have something nice to tell me? If it is not pleasant, Arthur, keep it a secret."

These incidents from different schools are typical of the way a progressive teacher handles tattling. She carefully avoids a punitive attitude and makes light of the reported "crime." She does this because she considers tattling an antisocial trait and wants to help the child to overcome it. In the old-fashioned school, rules are hard and fast and obedience to them takes precedence. Thus the teacher is—or, rather, was—not unwilling to have the children's coöperation in maintaining order. She was likely to answer: "You tell him to stop it quickly, before I come over!" or, "Tell him he'll have to pick up all the blocks before he can go outdoors with us." At home a mother who is busy with her housework and cannot keep her eyes on the children all the time is likely to give a similar answer.

The old-fashioned teacher took a punishing attitude and promised prompt retribution, while her progressive colleague usually tries to minimize the reported incident and to divert the child's attention. As the teacher quoted in the first example explained it: "Lois is jealous because Charles has this grand opportunity of playing with water by flooding the bathroom. Therefore, I suggest another kind of water play to take her mind off from Charles's doings."

The common denominator in the answers given to the children by their teachers was: "You need not worry. I can take care of things without your help." Often the teacher was irritated and thus unwilling to see that the tattling might be a symptom of the pressures the child was experiencing, the conflicts he sensed within himself. Yet the same teacher would be understanding and patient with the child who showed unreasonable fears or told lies. Sometimes a teacher said outright that she considered it mean to report the misdeeds of friends. To the child who follows her all day long with

tattling, a teacher may say indignantly, "Could you not do something nice yourself, instead of telling on other people?" [1]

Several observers mentioned that the tattling child seldom entered into vigorous play himself, while nothing that went on in the room escaped his attention—he seemed to see and to hear everything that went on. Tattling was more frequent with four- and five-year-olds than with younger children. There were about as many boys as girls in our material.

In trying to find the cause for tattling, teachers pointed to frustration, as in the case of the child who reported on her friend because she herself wanted to indulge in water play, and thus the teacher suggested another form of water play. Or the teacher felt that the child had latent possibilities for leadership, and that, if helped to develop those, he would be popular with his playmates and his urge for gaining favors with his teacher by spying on the others would diminish. One teacher reported:

> "I believe that Carol (five years, nine months) tattles so constantly because she holds the spotlight at home and would like to hold it at play school. Carol is not a leader; she uses tattling to focus attention upon herself. I generally listen to her stories, but I don't make an issue out of them. Carol resorts to tattling as it makes her feel important. She is not even concerned as to whether the teacher takes any course of action. She is just satisfied to tell the teacher."

And another observer reported:

> "P. M. does not seem so much interested in whether the teacher does anything to the person she is telling on as in getting the teacher's attention for a few minutes. When she comes to tell the teacher something, she seems very worried, but always goes back to play skipping and smiling."

These teachers drew the conclusion that tattling was for the children in question a device for attaining attention. Several teachers, however, reported that their methods of avoiding frustrations, giving personal attention in constructive ways, and promoting leadership worked with the mild tattlers, but had no effect upon the persistent ones.

A psychoanalytic interpretation of tattling may point to other reasons and may help us to see it as an indication of an important transition or of conflicts in the child, and to handle it more effectively.

[1] It is significant that there is a special term for the denouncing practiced by children—*e.g.*, "tattling." The equivalent German word is "*petzen*."

Some of the reasons that prompt a child to tattle are superficial. For instance, a child knows from experiences in his home or in a former school that the adult is likely to jump into action and stop Johnny, who is enjoying himself squirting water at everybody. The principle, "with malice towards none," is not more frequent among children than it is among adults. "The teacher [or mother, at home] stopped me, and if I cannot have it, nobody should." This thought is at the root of many "moral" restrictions.

There are still other reasons for tattling. The child is tempted to join in the wild, uncensored pleasure he sees, and he turns to the adult to gain protection from his own impulse. His tattling means: "Johnny is a bad boy. I don't want to be bad like him. Help me to be good." Or the child feels uneasy because he indulged in the same lawlessness yesterday, or possibly even to-day, without being detected. Now he projects his own guilt on the other fellow and experiences a vicarious feeling of relief as the other child is stopped or punished. Or the child wants to make quite sure that it is considered "bad" by the adult to throw blocks on the floor in a heedless way. He wants a generic rule, yet his thinking needs the support of a specific instance. He poses his question in the form of tattling.

The child who is afraid to succumb to the temptation takes to tattling because he fears the strength of his id; the child who tattles to gain relief from his guilt feelings is moved by his super-ego. A youngster may identify himself with the teacher's endeavors to keep order, or may want to make sure that certain actions are ostracized by her. In this case his ego propels him into tattling.

The child reports on others as he struggles to be "good" himself, to come up to the standards of the adult. The unrestrained behavior of the other evildoer reactivates the conflicts within himself. His own ego is weak and does not know where to throw its weight; therefore, he turns to his teacher or to his mother for assistance. If this our interpretation is correct, the widespread attitude of benevolent neglect or of minimizing the child's tattling is ill judged, as it denies the support for which he asks.

It may sound queer, yet the four- or five-year-old who spies on his playmates usually takes only a secondary interest in

their doings. His primary concern is the relationship between himself and right and wrong. This explains why sometimes a young child tattles only on his best friends, paying no attention to the misdeeds in others.

> Robbins, three years old, had developed a very possessive friendship toward Morton. All morning long they played together. At rest hour, when Morton was not lying perfectly still on his cot, Robbins turned to the teacher, reporting every move of Morton and always adding: "But I'm steady; I am a quiet boy now."
>
> The teacher was puzzled by this mixture of love and maliciousness. She was advised to get the child's background, as the reason for excessive tattling can often be found in home conditions. But in Robbins' case there seemed to be a good, easy understanding between parents and children. Later on, it was found that a young aunt who lived in his house worked at night and slept in the daytime, and Robbins had to be hushed all the time.

Occasional tattling indicates that the child is in the process of disengaging himself from certain childish pleasures. His ego is changing its allies and he needs our help in his orientation of "good" and "bad." He asks our support in his endeavors to be good. Frequent and persistent tattling indicates that the child is under too much pressure at home. For various reasons, the forces struggling within himself may be too powerful to be handled all by himself: The child may be too strongly attached to the gratification he has to give up; or his parents' standards may be too high, and he is expected to conform to them at a snap, without being given any time. By denouncing others, he gains relief, as we lessen a strain by inflicting actively upon others what we have had to endure ourselves. Or he is worried as to whether he will be able to be so good as to earn his parents' love and, therefore, cannot bear the sight of another person's indulging in the acts from which he so laboriously abstains.

Many righteous adults act in the same way, and thus are allergic to motes in the eyes of their neighbors. For an adult, too, it is easier to put up with restraints if he can at the same time inflict them upon others. A drinker who joins the association, "Alcoholics Anonymous" is, as soon as he takes the pledge to refrain from drinking, assigned another person whom he has to guide and to guard from drinking.

William James was pointing to another facet of the problem when he said: "It is one of the strangest laws of our nature

that many things which we are well satisfied with in ourselves disgust us when seen in others."[1]

In several instances of excessive tattling, we found that the parents' standards were by no means too high; they were indulgent toward the child, but either they were divorced or the marriage was about to break up. Apparently the conflict between them increased the child's anxiety, and thus accentuated the conflict within himself. An excessive tattler is a disturbed child who needs help.

Occasional tattling is a normal phenomenon in a young child. In most instances the teacher should convey to the tattler this feeling: "Yes, what you report is wrong, but it may not be quite so bad. Johnny or Diana have not been long enough in school to know any better. I don't think they meant to do any damage. Could not you walk over and tell them to stop and help them to clean up?"

If the child reports that somebody snatched a toy from him, the teacher may again turn over as much responsibility to the child as he can possibly carry. If he is afraid to go back to the aggressor, she may say, "I'll stay here where I can see you. You go and tell him to give it back to you."

There is an intimate communication between the things that we permit and that we deny to ourselves and to others, and also between the general strains under which we live. If tattling becomes endemic in a group, this should sound a warning to the teacher that she is setting her standards too high. Tattling is one way of bringing balance between inner and outer pressures—that is, the pressure that our own super-ego exercises and the pressure that the person in authority exerts upon us. One teacher had noticed that a child always spoke in a queer, high-pitched voice when tattling, quite different from her usual voice.

> After the first night in camp, a counselor overlooked the fact that one child in the group had wet his bed. Before long a youngster came to denounce his roommate. The counselor learned later on that this boy had been a bed-wetter himself until shortly before. This incident is very typical.
>
> Mary makes sure that the teacher sees every time some one misbehaves. "Miss B., Paul is standing on his chair." "Miss B., Jean is taking her name off the cup." (Each child's name is on his cup on a

[1] See *Principles of Psychology*, by William James. New York: Henry Holt, 1890.

piece of adhesive tape.) At the same time that she is telling the teacher, Mary starts doing the same things herself. She, too, stands on her chair; she also pulls her name off the cup.

Carol comes to the teacher and complains regularly about the bad language the others use. "Do you know what Sol said?" Pulls teacher down to whisper into her ear. "He said 'bastard' in school. I heard him." Carol herself not only delights in using obscene language on many occasions, but often for no apparent reason starts a singsong of some word like: "Cocky, cocky" or "Shit, shit."

Jackie, four years old, tattles all day long about all the other children. But he tattles especially to whitewash himself. He breaks a toy; immediately he goes to the teacher: "Michael broke this toy." It has been explained to him (and carried out) that he is punished for blaming another child, but will not be punished for the actual breaking. Yet he continues a behavior that brings no advantage to him. Does he lack intellectual understanding? Is maliciousness so ingrained in him that he would rather take punishment than change?

I do not think that Jackie's primary purpose is to avoid a punishment. Neither is it that he is malicious and enjoys getting the other child into trouble. It seems that he is under too much pressure at home and cannot admit to himself or to others that he did something bad. Jackie needs reassurance, not punishment, to deter him from blaming others. He may need to know that he himself is good and accepted, no matter what he does.

In this instance tattling is akin to the earlier mechanism of ejection which the very young child used. When he tells his nurse that the teddybear, or a "strange child," made the puddle on the floor, he is not primarily trying to escape punishment by telling a lie. He is trying to find a way out between the clash of two incompatibles: making puddles is definitely bad—he has just learned this; he himself is "good"—there can be no doubt about that. Thus the origin of the puddle must be pinned on to some one else who could be bad. In the mechanism of ejection the child purges himself of certain bad acts; in tattling he clears himself of the desire to commit such acts. It is as if he were saying: "I have no part in this. I even am actively on the side of the law."

Tattling will be infrequent if the child himself is still fully enjoying the thing he sees the other child doing, or if he has completely overcome the temptation to join in the forbidden pleasures. It is in the *transitory* stage that he takes to reporting on his comrades.

In the group of teachers who gave reports on this issue there was one who claimed to have solved the problem: Only new children attempted to tattle in her school. They stopped coming to the teacher after a few days. Her policy was to ignore a child's complaint completely. When a child persisted and went on tagging her and repeating that Henry had hit him with the swing, she finally replied: "Did Henry hit *me*?" To the child's astonished, "No," she retorted: "Then why do you come to me?"[1]

This teacher was carrying to an extreme principles that she had acquired in her training. She had learned that it was desirable for young children to make their own songs and their own poems and that on the walls of the nursery school pictures painted by the children were definitely preferable to pictures made by adults. If it is better for young children to produce their own art, she reasoned, they can also work out their own ethics.

A teacher who is so unaware of one of her essential functions may be infrequent, yet one wonders why so often an evasive answer is given to this childish request for moral support. The teacher sees mainly the maliciousness of the denouncer, or his attempt to boss other children and to busybody with matters which she can handle competently without his assistance. Few teachers are sensitive to the child's hard struggle to be "good" and to earn the adult's approval. The positive results may not be conspicuous at all times, yet the endeavor is present in every child who has an attachment to an adult.

We might say that teachers of the old school were taught that young children were wild, messy, and destructive, and therefore must be supervised closely and punished promptly; whereas enlightened teachers have learned that messiness and violence are needs of the young child and, therefore, we must stand back, permitting them to discharge their wild emotions and only protecting them from doing real harm to one another. Yet the child's inner struggle, his attempts to "evict" wishes that his beloved adult considers bad or just babyish, are quite

[1] I have developed the malicious phantasy that this young woman is robbed of her pocketbook in a dark street and runs to the nearest policeman to report her loss. Whereupon he calmly replies: "Madame, did he take *my* pocketbook? Then why—?"

obvious. Without the dynamo of this desire, the child could never be educated.

There is still another explanation for the teacher's reaction. In judging the young child's behavior toward his playmates, a teacher may apply a criterion that would be legitimate with *older* children. The school child who denounces a classmate is considered mean by his group. Older children feel knit together in their play, their plans, and also their mischief. They are pals, and the adult, even a well-liked teacher, is an outsider. It would be treason to let her in on a secret, and it is against fair play to tell her about a forbidden thing a classmate has done. This is true for the latency years.

The *pre-school* child's strongest tie is to the adult. He acquires a relationship to the other children in the group only via the detour of his wish to please his teacher. (This is also the way he accepts a new sibling at home—he senses what his parents expect of him and wants to comply. For this reason many children do not show any overt signs of jealousy.)

I would assume that teachers make this mistake because our memory is partial. Oblivion covers the time when we possessed no inner yardstick for good or evil—*e.g.*, the years of early childhood—while memories centering around the early struggles of our conscience, of the first years of latency, abound with many of us.

When the young child starts out in a nursery school, he will respect the rights of the others because that is what the teacher wants him to do. He will come to take turns, be willing to share, not because he is aware that the other child feels joy and pain just as he himself does, but because he wants to earn the teacher's approval. For the young child the teacher in the school and his mother at home are the center and the source of everything—of affection, protection, law, and knowledge. For the school child things have shifted: he respects the rights of playmates, because he wants them to honor his rights in turn. He has learned the law of reciprocity —to-day you need my help; to-morrow I count on yours. A bond of loyalty unites the group of children. Thus the boy or girl who reports a misdeed to the teacher is despised as a tattler.

Freud shows how, in the formation of a group, the feeling of group solidarity is preceded by that of rivalry as each one

aspires toward the exclusive love of the leader. This gratification is unattainable, and thus the drive switches its goal for one that is more remote, but that still offers a certain satisfaction—namely, equal treatment of all. No one should enjoy what cannot be enjoyed by all. "Each one renounces many things in order to make the others observe the same restrictions. This demand for equality is the root of the social conscience."[1] This transformation takes place under the influence of the attachment to the leader.

The infant is attached and obedient only to the all-powerful parent, while the school child is a social being who respects the equal rights of his playmates. The transition takes place in the nursery-school years, and such phenomena as close attention to the morals of his playmates, occasional tattling, and even glimpses of maliciousness appear as almost inevitable. They are the necessary cocoon out of which the sense of social justice, the feeling of group cohesion and mutual loyalty, grows.

SEGREGATION ACCORDING TO AGE

In large nursery schools, children are placed in such a way that all in one group are of the same age. The range within a group is usually from ten to twelve months. Recently some schools even have groups of "younger fours" and "older fours," and so on. Thus the age range is only about six months. Of course small schools cannot carry out this stratification according to age levels and this is considered a drawback.

The question arises whether this view is borne out by experience. A second question is whether psychoanalytical insight into the formation of the ego makes it advisable for a child to spend his school time prevailingly or exclusively with children close to his own age. Grouping according to age levels is an application of the principle of homogeneous grouping. The large elementary and high schools had—and in many instances still have—their pupils divided in such a way as to make each group as homogeneous as possible. That was achieved by combining grouping according to I. Q. with grouping according to age. To-day this seems an inheritance

[1] *Group Psychology and Ego Analysis*, by Sigmund Freud. New York: Boni and Liveright, 1922.

from the days when a high degree of permanency was ascribed to the results of an intelligence test.

In 1931, Alice Keliher took exception to this practice.[1] Among other things she was able to show that friendships as often crossed the lines of these groups as followed them. To the best of my knowledge, the positive value of a narrow age range in nursery school has never been questioned.[2] Only one author, Lois B. Murphy, has attempted a comparison of certain features of a group with a wide and one with a narrow age range.[3] Group "W" had 20 children with a range of from thirty-seven to forty-seven months, while group "H" had 19 children of from twenty-eight to fifty-four months.

For the problem that we are considering here, it is unfortunate that the two groups differed also in other respects. Group "H" had more play space and more equipment and the teachers showed more spontaneous warmth than those in group "W." The main object of Dr. Murphy's study was the children's spontaneous response of sympathy. In group "W" the ratio of sympathetic to unsympathetic responses was 1.63, while in group "H" it was 6.63. This is an enormous difference. However, on account of the peculiar set-up, we are unable to decide which one of the three factors—age range, play space and equipment, and teacher personality—caused it mainly or exclusively. Thus Murphy's study cannot provide an answer to our problem. The amazing difference between the two ratios only increases our curiosity.

How much importance do the children themselves attach to age? The members of our seminar reported frequent discussions among their children about age. The following are characteristic:

> Stanley, aged four and a half, stands in the yard and starts a conversation with children from the "Threes" across the fence: "You're a baby."
>
> Linda: "No, I'm only in the baby group."
> Marsha: "That is not a baby group!"
> Linda: "How big?"

[1] See *Critical Study of Homogeneous Grouping; With a Critique of Measurement as the Basis of Classification.* New York: Teachers College, 1931.

[2] At a recent meeting in San Francisco, Dr. Ruth Bendict questioned the tendency to separate children by ages.

[3] See *Social Behavior and Child Personality.* New York: Columbia University Press, 1937.

Marsha: "It's very big, up to the sky."
Ricky: "This is a baby group, but a very big one."
Alan: "This is the big baby group because we play on the sliding pond and swings when we go to the big yard."

A group of four-year-olds discusses the arrival of a new baby in Ileen's family.

Ileen: "He has brown eyes, black hair, and red cheeks and he rolls around a lot."
Joan: "Does he drink from a bottle?"
Ileen: "Yes, and finishes it all up. But I don't drink from a bottle because I am four years old. When he's four, he won't either."

Judy, three years and seven months, an only child, was very much interested in the babies in the park. One day she rushed up to a baby carriage and peeked in saying: "Oh, look at the little baby! Is not he little? I was a tiny baby once. I drank out of a bottle with a nipple when I was a baby. I am three years old now. I'm a big girl. My mommie does not give me a bottle."[1]

Children ascribe a great deal of prestige to age. We might qualify our statement by saying: children in our culture do. This can be observed even when the adults mention age only occasionally. The importance of being three or five is enhanced when the child's group in school is actually called "The Three's" or "The Fives." Just what makes a child five and another one four is not clearly understood by the child himself. Of course it is impossible to explain to a young child the passage of time, and hence young children fall prey to many misunderstandings, such as the following:

Richard: "I'm six."
Jeff: "Is he six?"
Teacher: "No, Richard is five."
Richard: "No, I'm six now."
Teacher: "Don't you remember your birthday cake had five candles on it? That means you were five years old—one candle for each birthday."
Richard: "Yes, but after my school party on Friday I had one home on Saturday, so that makes me six."

This point is also illustrated in a story by A. A. Milne, who often shows an amazing insight into young children. In his story a little girl, Barbara, finds herself convalescing in the country as her birthday comes along. The birthday party

[1] I should like to refer here to the earlier discussion on tattling—just speaking of drinking from a bottle brings the temptation to want to do it and the child immediately feels compelled to erect a barrier against such a desire, by stressing the distance between himself and the baby.

has been postponed, but her nurse arranges an impromptu tea party, and Barbara explains to her guests: "I'm six as soon as I get back. I would have been six to-day if I had been well." [1]

This may be taken as an example of childish realism in Piaget's sense—*e.g.,* mistaking a conspicuous consequence for the cause. However, there may also be another explanation: Not being aware of time, the child takes his respective birthday parties as a kind of initiation ceremony which the adults plan as they time and plan other things for him. At the birthday party the adults bestow upon him the status of being "five" just as a fraternity gives its club membership through an initiation ceremony.

Children have other misconceptions about age. M. had emphasized that he was five while A. was only four. A. retorted: "But next year I'll be five, and then I'll be six, and then I'll be older than you!" Here, again, the child hopes that age is a kind of status in regard to which you can catch up on others or even outdo them, as you can in regard to skills and possessions.

> Ronnie, aged six years and two months, has a cousin aged six years and ten months. The two girls are inseparable friends. To her teacher's question: "How old is your cousin?" Ronnie replied: "She is as old as I am, only she was born a little earlier."

Progressive educators call the lower elementary grades "The Sixes," "The Eights," etc., on the assumption that this will remove pressures from children. It may be a question of merit or demerit whether a child finds himself in the first or the third grade, whereas age is a biological fact and as such neutral. This is adult reasoning. Among children age carries as much status as grade in school. I have observed that most young children tell many more fibs and lies about their ages than they do in order to escape punishment. This indicates the urgency of the wish to be older.

In regard to adults, most children have a vague idea that they stay as they are and that therefore children will eventually catch up with their parents. Thus the typical remark of a little boy to his mother or to a well-liked teacher, "When I grow up, I'll marry you," makes sense to the child. It

[1] "Barbara's Birthday" in *A Gallery of Children,* by A. A. Milne. Philadelphia: David McKay, 1925.

seems to me that the child's belief that he will catch up with his elders is not entirely mistaken. The numerical difference in years remains, but the difference in status shrinks rapidly. The relationship between a sixteen-year-old and his parents is very different from that of a six-year-old and his parents. Many children also believe that getting old means getting smaller and smaller. There is a vague notion that death is the end of this continued shrinking. A child who passes through a period of acute fear of death will thus be doubly glad if told how much he has grown recently.

Even this quaint idea that adults get smaller may be based on partly correct observations. Grandparents as a rule are considerably smaller than parents in our decades. This is not only because they walk with a slight stoop, but mainly because for about a century, because of more favorable environmental conditions, children have tended to be taller than their parents.

Freud has stated more than once that the wish that dominates childhood is the desire to grow up. From whence does this wish derive its strength? The Œdipal attachments dominate this period, and the three-to-five-year-old suffers minor and major rebukes in his efforts to be taken as the full partner of his parents. He ascribes his lack of success, at least at times, to the fact that he is too small and too young. The boy who fails in competition with his father derives a grain of relief in finding that, nevertheless, other boys who are older than he take him as their equal. Sometimes he needs to know that others look up to him and that he can be their protector. He now can be at times the active party, in a relationship similar to that in which he is the receiving party only at home. Thus the two antithetic situations—"I'm smaller than X, yet he accepts me as his friend; I'm stronger and bigger than Y, and thus I can protect him"—provide relief from the burning wish to grow up. In an environment that is planned for his optimal growth, a child should be able to associate with others who are his own age as well as with older and younger playmates. According to our experience this applies to children of nursery-school and of elementary-school age.

For a comparison of a group with a narrow and one with a wide age range, let us turn to Murphy's forementioned study.[1]

[1] *Op. cit.*

> "The differences in group H were great enough (they were thirty months) to avert constant competition for the same play materials and activities, and to stimulate a protective, 'big-brother' type of response of older towards younger children. There may doubtless have been important imitative factors: when older children set examples of protective and sympathetic behavior, these would be copied by younger children when occasion offered. Group W, on the other hand, consisted of children developmentally close enough together to be interested largely in the same materials and activities; this necessarily resulted in more competition and conflicts over these materials. And the same imitative factors that were present in Group H and which led younger children to pick up coöperative and helpful patterns from the older ones, would result in acquisition of more techniques of conflict in Group W. In this connection it is interesting to note that for three successive years, groups occupying the present quarters of Group W had shown high conflict scores, as compared with groups in the quarters of Group H."

Murphy describes how feelings of protectiveness in the older children are substituted for competition, aggression, and defense. I should like to supplement her excellent description by pointing to the corollary feelings in the younger children. They look with great admiration toward the older ones and are happy and flattered when drawn into their play projects. And yet in the same children, when with playmates of exactly their own age, the strife for ascendency would be foremost. Each child would want to be the first. There would be the strong urge to outdo the other fellow in physical strength, in cunning, in number of friends, and so on. Consequently there would be a good deal of boasting, quibbling, fighting, and suspicious watching intermingled with their play.

In the *Haus der Kinder* in Vienna, all groups of children —those on the pre-school level as well as the regular school groups—had an age range of two, two and a half, or three years. In contrast to the educational views held in this country, we never questioned the fact that a wider age range is more conducive to the child's emotional, social, and intellectual development and lessens the feelings of inadequacy generated by the Œdipal frustrations. Thus control groups with a narrow age range were never established, and our experience lacks the support of experimental proof.

Often a younger child became attached to an older one and showed distinctly what would be termed hero worship in an adolescent. A child seemed well satisfied when a group of older children who were building or working at the car-

penter's bench permitted him to carry blocks or pieces of wood back and forth for them. The school children did their regular school work in self-formed groups, sitting around a table, and here, too, a younger child seemed quite content to be permitted to sit with them and watch them. Precise records are no longer in existence, yet I remember that we were at first uneasy seeing a child assuming for too long periods the rôle of the inactive observer. With a young school child we were worried as to whether he would not fall behind in his own school work. In each instance, however, the period of being an onlooker ended without direct interference on the teacher's part, and the child returned to his own work with a new zeal.

There is no doubt that Dewey's principle of "learning by doing" is correct, yet the interpretation that doing must always be some muscle activity is too narrow. Apparently the child who sat and eagerly watched an older friend was "learning by looking" or, in instances in which the older child's school work was beyond the younger child's technical understanding, he derived from his association with the older friend a heightened incentive to go on with his own work.

In recent years I have worked prevailingly with schools whose groups were strictly stratified according to age. In some instances the school had the practice of "graduating" a child to the next group the very day he turned three or four. The birthday party was at the same time the child's farewell party. The party as such was certainly helpful, yet, with the turn-over of teachers and children in New York City's nursery schools and kindergartens, it often meant that the child severed his attachments to his teacher as well as to the majority of his playmates twice a year—he entered one new group right after his birthday and another in the fall. For children whose family life was of average stability, this had no patent bad consequences. I remember, however, A. C., whose transference to another group on his fourth birthday coincided with his father's leaving for the army. He showed signs of serious disturbance which subsided when he was returned to his former group.

Far more frequent is the reverse case—*e.g.*, a child in need of promotion to an older group. A child finding himself in a group in which everybody is his own age may become so

unmanageable that the school considers asking the parents to take him out. When, as a last resort, this youngster is placed in an older group, he may make good.

> Betty, five and a half, and Frankie, three years and five months, had been in nursery school for one year. They were in different groups and met only in the yard. There were three older children in the family. In February Betty entered public school. She called in the afternoon with her mother for Frankie. He became very unhappy, refusing to join in any activity whatsoever. He would sit and sulk for hours or seek trouble with some other child. He ignored his sister completely when they called for him in the afternoon.
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> For two months his teacher and the director of the school tried everything to help him. As a last resort he was transferred to the older group, although he acted more infantile than he did when he first entered the school. It worked like magic. He became his old self again. In the afternoon he greeted his sister with "I've been promoted. I'm a big boy now." Since then several months have passed and Frankie has been accepted by the older group.

As long as both children attended nursery school they had an almost equal status. Betty's promotion in the middle of the year, however, meant indirectly a demotion for Frankie. That he is the youngest of five siblings may have increased the pressure he felt and his reluctance at being "left behind" while everybody in his family grew up. The fact that the promoted sibling was a girl probably increased the aggravation.

The mechanism underlying such a successful adjustment is a kind of silent barter. The adult promotes the child, thus increasing his status, and the youngster in return makes a more determined effort to please the adult and restrain himself. In some cases the child had been getting out of bounds because he was the unchallenged leader in his group or because he was the child with the longest group experience and, therefore, the greatest social facility. Joining a group of children who are a better match for his abilities makes him more willing to accept also the adult authority. A healthy child cannot enjoy a placid, static existence. He has to pit his strength against that of another person. If there is no other youngster against whom he can test his abilities, he will test them against the adult.

Recently some nursery schools have introduced the practice of having children visit older groups, either for special activities or for half days and, in at least one school, the corollary practice is being used—one or two older children may come

to a younger group and help the teacher if they want to do so. The visiting is very helpful in overcoming an isolation that in the long run is apt to impoverish the formation of ego ideals. This is of course more true for children attending all-day schools than for those in half-day sessions.

A school that is centered around the principle of the teacher's guiding and supervising each child will simplify the task by striving for uniformity among the pupils in one group. The administrators and attendants of any institution in which people are taken care of aim at homogeneity to simplify their work. This is a sensible policy, whether the charges are newborn infants, physically sick people, or mental patients. A school also "takes care" of children, but this is only preliminary to its focal interest—the children's social and intellectual growth.

A school that capitalizes the influence of one youngster upon another needs interaction between them, and this in turn is predicated on variety among the group members. Homogeneous grouping is not compatible with the "embryonic society" Dewey wanted each classroom to be.

Assuming at times the rôle of the older, the protecting friend, and at times the rôle of the follower, the receiving party, broadens the development of the child's ego and strengthens his feeling of competence. A wider age range increases the occasions for such relations.

Rewards and punishments meted out by the adult group leader, the teacher, are the main educational tools of an education based on "training"—*e.g.*, enforcing desirable behavior until, by dint of frequent repetition, it becomes a part of the child's character. If we accept the psychoanalytical view of human development, identification becomes the most effective lever for the shaping of character. In a group with a wider age range, such opportunities are increased, and there the child also finds a wider selection of individuals with whom he can identify.

In a homogeneous group, coöperation is mainly on the basis of quantity: "I do this half; you do the other half." If the members of a group *differ* in their abilities, there can be another kind of coöperation: "I do what I can do well; you apply your skill." It is obvious that—*ceteris paribus*—there will be less mutual helping out and more competition, more

comparison, in a group all of whose members have about the same abilities. The modern nursery-school teacher avoids comparison between children and avoids arousing feelings of rivalry. Nevertheless, in a homogeneous group a certain norm of performance becomes established and small deviations attain a high visibility. The children themselves, as well as the teacher, are aware of the child who excels in building or painting or of the other child who is more slow or clumsy in dressing or eating.

In a group of differing ages, wide varieties in performance are the order of the day. Within this general diversity, differences between children of equal age disappear or are taken casually. It is well known that in a family in which siblings of the same sex are close in age, competition is far more dominant than in families in which the difference is more than three years.

A large nursery school that could open parallel groups, alike in every respect except that one would have a wide and the other a narrow age range, would be in an ideal position to test the respective advantages and drawbacks of homogeneous *versus* heterogeneous grouping.

SIBLINGS IN SCHOOL

To-day we believe that the family constellation and the emotions experienced in early childhood are the deepest formative influences. There are feelings of love and of hate between all the family members. In the complete family, it is difficult to gauge the respective strength of these feelings, since one neutralizes part of the other. Thus observations of *incomplete* families assume an increased importance. If one parent is missing, the child's feelings toward the parent who is left will show an over-intensity of love, or, if the child blames the remaining parent for the disappearance of the other, of hate. In view of the young child's utter dependence, the latter cannot be of long duration.

During the war years Anna Freud and Dorothy Burlingham had ample opportunity to observe children whose families were incomplete.[1] Let us take the case of Tony, who had lost

[1] See their *Infants Without Families*. New York: International Universities Press, 1944.

his mother. At first he behaved toward his father as if the latter had actually deprived him of his mother. "Hate is aroused against the father where his presence seems to separate the boy from his mother; left alone without the mother, son and father are the best of friends."[1] With Tony his passionate affection for his father was accentuated since it covered the previous feelings of the opposite nature and probably also because Tony lived at the nursery and saw his father only on visits.

> "Tony fashioned the phantasy of a father to whom he formed the most passionate, loving, and admiring relationship. When he was about four years old, his father was seldom absent from his thoughts. All his interests centered around him and he mentioned his name continuously in every conversation. When he picked blackberries, flowers, leaves, he wanted to keep them all safe for his father. When he disliked having his hair washed, he asked: 'Does my Daddy cry when his hair is washed?' . . . He would eat greens though he disliked them, so as to 'get strong like my Daddy.' The big toe was for him 'the Daddy toe'; every army lorry on the road meant for him the lorry of his father's army unit. Whatever deeds of omnipotence the other children ascribed to God, Tony ascribed to his father. . . .
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> "After one of the father's visits, Tony did his best to keep his image alive by imitating him. He developed a morning cough because his father had coughed in the morning. At breakfast he stirred his cornflakes with his spoon for a long time, saying: 'My Daddy did this when we had breakfast together.'"

The authors conclude their observation: "Wherever the father's influence made itself felt in Tony, urging him toward efforts to become manly and courageous—not to cry, to eat greens—these were the result of *spontaneous imitation* of and *identification* with his father and not due to any *restrictive* or corrective actions on the latter's part."[2] In permanently or temporarily dismembered families the relationship between the remaining members is altered. There is a different love-hate balance and there is an increased readiness to honor the restrictive demands of the absent parent.

In the present paper we have collected observations on one type of temporarily incomplete family—siblings attending together nursery or play school. In most instances (exceptions will be discussed) the older child demonstrates an amazing degree of protectiveness and concern for the younger child,

[1] *Ibid.*, Chapter on "Relationship to an Absent Father."

[2] Italics the present author's.

who in turn is very submissive and compliant. Both children deviate from the typical behavior of their age—as long as they are in school.

Between young siblings feelings of rivalry usually are turbulent, and love and mutual loyalty can be more often inferred than observed. This situation is reversed when sister and brother find themselves together in a group of strangers without their parents. The formalized conditions of the grade school make observations difficult, but in nursery school or in afternoon play groups, the protective and the submissive behavior are evident, once our attention has been attracted to it.

Sixteen pairs of siblings were observed, plus one pair of twins. In twelve cases the older child showed a protective and at times a bossy attitude toward his younger sibling. He also displayed amazing patience. We are accustomed to think that a healthy youngster cannot resist the opportunity for vigorous play, let alone a repeated invitation to it, yet several of the children observed preferred, in their first weeks at school, to sit quietly and watch the younger child. The teacher tried hard to get Harry, aged four years, four months, to join the other children's play in the morning. She persisted in spite of his refusals until he found the one answer that settled the question: he was tired from walking to school. However, in the third week, after he had gained confidence and did not think that he had to watch his brother all the time, he joined the children in their play. Harry is only twelve months older than his brother!

We like to think that the feelings of young children are like an open book to us and that, in contrast to adults, joy, disappointment, or frustration are clearly written on their faces. Harry's sitting still and abstaining from play certainly entailed a sacrifice; but there was no indication of this. His behavior was "seamless." Probably more often than we know young children undergo inner struggles that are as well hidden as those of a mature person.

Others of the observed siblings were in different groups and met only on the playground. Then they would rush toward one another and the older child would often prefer to sit with "his baby brother" or to walk around holding hands and displaying the younger one like a doll. One was not sure

whether the younger child preferred this kind of rather inactive display or was given no choice.

When the younger child was attacked, his sister or brother not only came to his defense, but expressed more hostility and violence than were ever shown in self-defense. If the younger one hit the older, the older did not retaliate, but either ignored the blow or turned to the teacher for help. The same child would hit back readily when attacked by others, but against his sibling his self-defense was impaired in school. The older child would even start to cry and yet not retaliate.

In those cases in which it was possible to supplement the observations made in school by parents' reports, the children behaved quite differently at home. Carol, four and a half, was so solicitous of her younger sister, Jeanne, two and a half, that she insisted upon lifting her in and out of the swing, although Jeanne could get in and out herself. At nap time Carol would get up several times and cover Jeanne. Now they are in different groups, yet Carol runs to the door if she hears crying to see that it is not her sister. The mother reports that at home Carol takes nearly everything away from the younger sister, slaps her, and so on.

It may be argued that in both situations Carol acted really in the same way: she used and displayed her greater power. Yet the problem remains that in school she succeeded in doing this in a socially acceptable way, while at home she failed.

At home parental restrictions are often "forgotten" when the parent is out of sight and quarreling starts. Why are they "remembered" in school, where the parent—and thus the risk of being found out—is further removed? I am not sure that I have a satisfactory answer. It may be that identification with an absent parent is easier than with one who is next door. The child cannot impersonate a parent who can step into the room at any time. Or it could be that at school the children do not feel quite sure whether the parent will call for them, and this anxiety provides an added incentive to be good. To put it in still another way, at home the child is afraid of the parent, who has set restrictions and who is nearby. In school this fear of immediate punishment is canceled. Instead, there are feelings of longing for the absent parent and these strengthen the commands of the super-ego.

The young child's super-ego borrows its strength, as well as its content, from the parent.

Tony, whose father sets no restrictions, deduces himself specific restrictive and corrective measures which seem in line with his father's behavior, and abides by them in a more exacting way than a child who receives explicit restraints plus threats of prompt retribution. The child's super-ego gains executive power by the temporary absence of a beloved parent or parents. If this observation can be proved on a broader basis, it has important educational implications.

In our material the actual age difference seemed of no importance. A child who was but ten months older was as likely to treat the younger one as a helpless baby as a child who was three years the senior and thus really more provident. In a larger material differences due to age and sex will probably appear. Deductions from our material cannot be conclusive, yet it indicates a greater competition between two sisters than between brothers or siblings of mixed sex.

Four pairs of the siblings observed exhibited in school more hostility, aggressiveness, and maliciousness toward one another than they showed toward any other child. Two pairs were of mixed sex, and there the girls were the aggressors. Sheila, aged five, would beat her brother Sam, aged four, after a few minutes of play, pull off a piece of his clothing, or snatch a toy from him and run away with it. Mary, six years, who attends an afternoon play school with her brother Gerald, aged seven years and seven months, "will wait until her brother has constructed an intricate piece of work which has required ingenuity, time, and patience on his part. As soon as she can, Mary will knock it down or destroy it and seems to derive fiendish glee and satisfaction from her brother's disappointment." Gerald's I. Q. is 126, Mary's is 113. Gerald was born with a clubfoot and underwent several operations. His sister is physically stronger and usually overpowers him when they have a fight.

The two other pairs of siblings in whom unkind behavior outweighed friendliness were sisters. They ignored one another most of their school time. In all four cases the parents showed outspoken favoritism toward the child who was the aggressor. After this had been observed, the teacher tried to remedy the situation. With Mary's and Gerald's parents, teacher conferences relieved the home situation and conse-

quently improved the children's relationship in school. When the teacher tried to point out to Sam's mother that he was treated with much more love and attention than his sister, the mother's response was that, after all, Sam was still a baby.

Apparently strong favoritism at home interferes with the child's desire to identify with the absent parent and to copy his attitude. Instead, resentment is stored up at home and discharged in school.

Let us return to the pairs in which love and submissiveness prevailed. The overprotectiveness was most outspoken in the first weeks and melted down as the siblings felt more at ease with the teacher and the other children. In the beginning the older child did all the talking for the younger one and did not permit a direct contact between his younger sibling and other children, Babs, aged four and a half, had a hard time making her brother, aged three years, nine months, do as she wanted. She tried to overpower him in a quiet, persistent way, never shouting or hitting. Many times a day she turned to the teacher: "Jack spilled all his juice. Now he's all wet." "Jack mumbles to himself." "Jack won't fasten his zipper." However, her tattling was done very quietly; she always whispered to the teacher as if she did not want the others to hear her.

After the first weeks, Joy, four years and three months, gave Dave, three years, one month, a chance to play with other children. However, at any interruption, such as milk time, going to the toilet, or dressing, she ran over to her brother and did everything for him. Observations of several children mention the eagerness of the older sister to take her brother to the toilet. Marianne, four years, eleven months, is consistently protective toward Edna, three years and ten months. The latter, however, alternates between friendliness and rejection. For instance Marianne is found crying on the playground: "Edna is my sister and she won't play with me." On one occasion Edna broke three times the car that Marianne had constructed from blocks. Marianne did not defend herself, but started to cry. As Edna was about to join another group of children, Marianne called over: "Don't let Edna into your house!" Thus malicious orders to other children represent the utmost that Marianne can do to defend herself against her little sister. At home she is quite capable of holding her own.

It might be argued that we are not dealing with a genuine psychological phenomenon that needs any explanation—the children were simply carrying out their mother's orders. Certain aspects of the older child's behavior could be explained this way. But it does not cover all the incidents. The less so as we know how quickly as a rule young children forget mother's orders when they are away from her, unless there is a special reason, such as a feeling of guilt, to reinforce the maternal commands.

In some instances the observer did not know which astonished him more—the older child's willingness to forego play activities in order to take care of the younger child, or the submissiveness with which the younger one endured the older child's bossing.

In the twins—boys, aged four—neither protectiveness nor submissiveness was outspoken. They played with other children, yet after a short while, each always had to find out what the other had been doing.

The described instances of "philadelphism" (brotherly love) have their counterpart in the Hansel and Gretel phantasy of latency years spun often by a child who may be neither the oldest nor the most pacific among his siblings. Orphaned or deserted and badly treated by their parents, he protects the other children and with their pooled resources and cunning, they fight successfully fire and storms and the wild beasts of the forest, and outwit the old witch.

These observations also reminded us that in societies in which the relationship of mother and child is less close, there seems to be far less sibling rivalry.

A good deal of our understanding of the young child's needs is of very recent origin and is in sharp contrast to the tenets of good education two decades ago. Thus research and discussion have so far been focused on the child's most obvious requirements—motherly affection, unhampered play, physical gratification. Perhaps the time has come to turn our understanding and our support to the less clamorous and less obvious aspects of his growth. In the observations reported and interpreted in the foregoing pages, we have tried to increase our awareness of some of the foreshadowings of his social and ethical development.

THE SOCIAL FUNCTION AND GROUP THERAPY

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DURING the past generation great emphasis has been placed by the medical profession on the personal internal workings of the individual. Overwhelming stress has been laid on the sexual adjustment of the person, and the problems of his social adjustment have been brushed aside. Even social workers, despite their name, with their intensive case-work procedures, have veered off in this direction, and medical thinkers in general have lost track of the idea that humans are basically social units.

None the less, the most generally important skill a person can have to help master the process of living is the ability to live comfortably with others. Without this art one becomes emotionally isolated and suffers from a really crippling disability. If it is impossible to get along with one's fellow man, the whole organization of life is affected. One cannot move with confidence in any direction. The forests become filled with nightmare figures because reality is dim and inconsistent. Anything becomes possible. Unless one knows what people are really like, unless an underlying awareness of friendliness exists, it is all too easy to think the neighbor may be an enemy. Threats appear on all sides, and there is no balance wheel of human give-and-take to prevent a person from spinning wildly away from specters.

Therefore, in friendless adults mental illnesses arise, and in friendless children the whole stream of life may be turned aside. The healthy child who does not make friends may become sick. The good adolescent who is cast out by his group may become bad. To accept and to be acceptable is a most important stabilizer for the individual. Otherwise destruction threatens.

The need for companionship is not confined to the human race. So much of the activity of animals is directed only toward achieving satisfying and stabilizing contact with their

own sort that it takes on the aspect of a deeply moving biological drive. This is especially apparent in the behavior of many vertebrate groups. Some fish, for instance, habitually travel in formations. If one of them loses contact with its school, its behavior is frenzied and disorganized. All its activity is directed toward joining up again with its own group or another. When it rejoins its peers, orderly, purposeful behavior is immediately restored. It looks as if there is an immediate release of anxiety in the fish as it swims in formation side by side with its friends once more.

Similar observations have been made by naturalists again and again, for many kinds of animals and in many settings. Thoreau has described the group play of cattle: "I saw one day a herd of a dozen bullocks and cows running about and frisking in unwieldy sport, like huge rats, even like kittens. They shook their heads, raised their tails, and rushed up and down a hill." And Emerson writes of snakes: "After much wandering and seeing many things, four snakes gliding up and down a hollow for no purpose that I could see—not to eat, not for love, but only gliding." The aim of this group activity seemed to be pleasure only, and the satisfaction was obviously derived from companionship with others of the same species.

The famous ecologist, Dr. Warder Clyde Allee, has studied this subject exhaustively and has accumulated some very interesting data experimentally to show that companionship and its underlying determinant, companionability, are not just frivolous, but actually serve a definite biological end. He has shown, for instance, that few animals are more class conscious than the hen. In stable flocks each hen recognizes her social position and accepts it without demur. This becomes apparent through the pecking phenomenon. Hens peck at one another in fixed order, from the upper class down through the lowliest scullery maid, who, poor thing, has no one below her to peck at.

If these flocks are left alone, they become a very stable society. But if the social scene is kept in turmoil by constantly subtracting and adding hens, Dr. Allee finds that the social restlessness is bad for the hens' health, and that "organized flocks eat more, maintain weight better, and waste less time in undirected antisocial activity than do members

of an unstable flock." In other words, they are more productive. Their morale is better. They are less neurotic. They do not have to waste their energy in jockeying constantly for status in order to feel secure in a changing world.

The importance to each bird of belonging to a group of trusted and familiar friends closely parallels the situation expressed by children and their parents in moving from a familiar environment to un unfamiliar one. Dr. Allee says: "Even in strange territory, a bird wins more readily if it is in the company of others with which it has already associated." A parent says: "I am sending Fred to Milton so that when he goes to Harvard he can enter with a group of friends." Indeed the beneficial, as well as soul-satisfying, results of accepted and acceptable companionship have been so generally recognized that solitary confinement is almost the most grave punishment an individual can be subjected to in our society. One vast group of the major psychoses (the schizophrenic) appears to be based in large part on the individual's inability to establish resonant, meaningful relationships with other members of his species.

For the child, opportunity to become an integral member of a group, and the ability to take part in the social scene, are absolute essentials for normal development of his personality. The inability to make friends and to feel befriended is a crippling handicap that will distort the growing personality to as great a degree as frustration of the child's developing sexuality. Both the social and the sexual functions are instinctively ordered biological drives, and both are subject to many kinds of blocking and repression. If an abnormality develops in social behavior during the growing-up period, it may take any shape—from complete withdrawal, in which the child gains nothing, to over-eager participation, which causes him to be rebuffed so that in the end he also loses. In either case, a damming back of the developmental energy flow is occurring, and the child is the listless or rebellious victim of a crippling illness.

The problems of many maladjusted children have grown like barnacles on a rock around the fact that the child cannot make friends. The parents of adolescents frequently complain that the youngsters insist on clinging to a socially unacceptable group, although social isolation is also common. In either case

it is usual for other difficulties to develop. The child's failure to win acceptance by his group often throws him into a generally rebellious or anxious network of symptoms, frequently called "behavior disorder." During the course of successful treatment in this group of children, many kinds of symptom that might appear to be totally unrelated to the lack of social success—such as nightmares, stealing, tantrums—may drop silently out of the behavior pattern once companionability and the capacity for participation with his contemporaries have been restored to the child.

The relation of social isolation to delinquency is apparent to most people who study juvenile misbehavior. Young children suffer bitterly from group rejection, but the adolescent suffers even more poignantly when he is unable to win acceptance. The young child after all has his family to snap back into if the outer world repudiates him. But the adolescent's ties to his family are weakening, and the value of family refuge is deflated as the importance to his feeling of self-esteem of earning personal success in the outer world becomes inflated. Thus the desperation of the adolescent mounts, until finally nothing else matters to him at all except winning a position for himself in a group. Ultimately he feels that just any gang is better than no gang at all, and any method of gaining a position for himself is justifiable.

For instance, Joe appears before the juvenile-court judge for taking automobiles that he found parked along the street. He has not apparently wanted to steal the automobiles, for he has left them again by the side of the road, uninjured, within an hour or so after taking them. He has been reprimanded and remonstrated with, and each time he accepts the scolding with humility and a promise that he won't do it again. But finally, after he has done it again for the fourth time, the judge sends out for an investigation.

The policeman who brought Joe in has often seen him standing on the corner with a group of young roughnecks. He is smaller than they, but he is holding them spellbound with some yarn he is spinning. With the adult, Joe is at first reserved and evasive, but as he feels more comfortable, he warms up to his subject and tells a dramatic fantasy story about his activities that makes the automobile incidents a pale and symbolic part only of the total theme. The ease with which

he goes into this story shows that much time and energy have gone into polishing up the details for a wider, younger, and perhaps more gullible audience. The fantasies are not just roughed in. They are elaborately finished. The policeman reported how effective Joe was as a spellbinder when he saw him dominating the street-corner gang.

This is Joe's first year in high school. When he was in the seventh grade, his family moved to town from a farm because the farm had been flooded out for three consecutive springs, and the father was completely discouraged with farming. The seventh-grade teacher knew that the boy was not getting on socially with the rest of the class. He was a newcomer. His clothes weren't right. He was rather small, and sensitive about it, and he was no good at athletics. The teacher had watched him make overtures to the other children and had seen them repeatedly repudiate him with the casual cruelty of young adolescents. She had even made abortive attempts to help him by giving him privileges in the schoolroom, seating him up near the front, and asking him to run errands, but she was aware that what she could do was inadequate to alter the large fact that he was really not able to win status with the other children.

The nice children would not accept him, but he found a group of youngsters who would. And he found by the trial-and-error method that even if he could not compete on the basis of athletics or personal charm, he was able to maintain a solid front-line position in the group by spinning yarns. He developed such virtuosity in this technique that he found himself quite carried away by his own stories, and the car incidents were just a small part of his fantasy which he put into actual practice. The delinquency pattern resolved itself simply into a method for making friends. For Joe it was the only method at hand, and the need for friends seemed to him to be a matter of life or death.

A pattern of delinquency like Joe's, or a behavior disturbance in a younger child, becomes a vastly complicated picture. Once a child gets off the track of normal development, every element in his environment becomes tinged with the colors of his illness. Therefore, treatment for children with problems has been approached from many different directions, depend-

ing on what aspects of the whole picture struck the examiner's eye, and also on what treatment resources were available.

The common methods that have been used have included dosing with glandular products (as thyroid and other endocrine preparations) and drugs (common phenobarbital). Efforts have been made to alter the environment in many different directions—as, for instance, placing the child in foster homes, institutions, or schools. Many individual techniques have been developed by psychiatrists and others for modifying by person-to-person methods the personality structure, the attitudes and points of view that are thought to be disturbing the individual.

All of the methods that have been used have been successful in some cases, and all have failed in some. In general, individual treatment, which attempts to reshape the personality, is the most expensive, and, therefore, for the mass of the population, the least accessible. Also, the interview technique often fails, especially in adults during the course of major mental illnesses, and in non-verbal children. The interviewer may also encounter difficulty with the excessively talkative child who runs away with the interview, but whose conversation is only a shield for his anxiety and has very little connection with the reality of his overt behavior.

Also, the interview technique when it is directed toward an intense, intimate relationship between the adult and the child may actually serve to prevent the child from seeking companionship with his peers. Although many children are badly in need of comfort and acceptance from an adult, the danger exists that the timid or low-energy child will find the relation ship too comfortable and use it for continuing his dependency instead of directing his efforts toward establishing status and relationships in the more troublesome setting of his contemporary group.

Psychiatrists and counselors often complain of defeat in their attempts to establish workable relationships with adolescents. They complain that they cannot make some of these children talk. This represents a healthy resistance on the part of the youngster. In this age group the normal individual may develop an emotional attachment to the adult, whom he may idealize as a hero, but intimacy in the close friendship

bond should normally turn away from adults, and be directed toward contemporaries.

Much has been said about the benefits to a family-bound adolescent of establishing a close bond with a non-family adult. I do not minimize the importance of this. The adult in the hero rôle plays an unique part in freeing the adolescent from his family bondage. Through an identification of the weak adolescent with the hero, the child may take over the whole personality of the adult, and in some cases it may be an essential step in freeing the child from his parents enough so that he may really establish his own sense of being an individual with an independent existence outside the family.

But the limitations of this relationship must be borne in mind. Little benefit is gained by the child who substitutes an artificial indulgent parent for a real one, unless the attachment is used as a tool to maneuver the child into better relationships with his peers. Danger lies in the fact that the youngster may rest even more inert in a new comfortable situation than he did in the bosom of his home. Deep intimacy and dependency on an undemanding adult, who may be a teacher, scout master, or any one who takes a persistent interest in the child, may further invalidism if it is so satisfying that the adolescent does not feel the internal drive toward friendship with contemporaries. Forcing this intimate relation with an adolescent, therefore, may block the normal stream of energy and be in this way an affront to the youngster's biologically motivated reserve.

Aside from these dangers, the interviewer who succeeds in establishing a good relation with the child is still able to perform only in a limited sphere. Retreat to the office bears about the same relation to the stream of life that retreat to an air-raid shelter does to the prosecution of a war. One cannot really live unless one can leave the shelter to meet the problems of reality. Certain kinds of theoretical consideration can be worked out in seclusion, but without the actual situation at hand, there is a rigid limit to what can be achieved, for words are poor substitutes for action and talk is often only loosely related to behavior.

Recognizing the limits of this relationship, play techniques have been developed, so that talk as the only medium of exchange has been replaced by action with toys. But even this

method is limited by the fact that the toys do not react to the child. If a child throws a doll on the floor and stamps on it, the doll does not hit back and thus educate the child by responding to him. The child is left with the burden of his guilt and the anxiety that goes with it. In the setting of interreaction between children, the child has the golden opportunity to learn what responses his behavior will elicit. If the situation is controlled and thus not too frightening, he can then modify his behavior to get the response he wants. Children can learn to get on with other children best by being exposed to other children, in tolerable situations.

The group-therapy method approaches the problem of social isolation directly, by working specifically on the social functioning of the individual. This method also eliminates most of the disadvantages of the various techniques described before. Thus it does not create invalidism and hypochondriasis by emphasizing medicine. It also eliminates the mother-child tension existing between a mother who chases a rebellious youngster around the table to dose him, and the child himself. The child's own feeling of being different is reduced. The child no longer thinks, " I'm not like other children. I need to take medicine." Since it is a group method, it is less expensive than any individual method. Since the rôle of the ideal group therapist is one of passive, accepting friendliness, without any elements of possessiveness, the problem of the excessive dependency which may be so hard to handle by the person-to-person method is largely eliminated. And most important of all, the success of the method lies in the fact that continuous emphasis is placed on the relationships between the individuals in the group. The important and curative relationships are between the sick people themselves, rather than between a sick person and a well person, as in any person-to-person method.

Group therapy is a simple enough technique. It consists only in the presence of a small number of people, eight or twelve, together for the purpose of discussing and understanding some particular problem. The problems may be of any sort. For instance, a group of shy adolescent girls may form a club, or a group of adults with headaches or ulcers, or a group of parents with problem children may meet together. There is a group leader present, to be sure, but the less appar-

ent and obtrusive he is, the more successful the group will be. The curative thing that occurs is a modification of the behavior and attitudes and state of mind of the individuals, which is brought about by their coming to know one another, accepting one another, and reacting to one another.

Whenever people find themselves in trouble or facing a common problem, development of group spirit gives them a chance to share experiences and relieve one another of fear and guilt through seeing that they are not alone, but that others are in the same boat. Thus, the individuals in the group can shift attitudes and points of view, frequently without being conscious of what is happening, and derive great benefit in their behavior and emotional states from so doing. Beyond this, too, taking part in groups serves the pleasure principle as surely as gratifying any other appetite does, for the need for social communion is an appetite like the others. Thus, an important balance may be restored to people who have been deprived of this outlet, and more normal reasonable behavior may result as tensions and social deprivations are relieved.

Group therapy, then, is a multi-potential tool and it can be used in any situation in which the social function is at fault, or in which social and family relationships are causing trouble. Delinquency and the behavior disturbances leading up to it are certainly an expression of the child's social maladjustment. But pushing the cause a generation back frequently shows that the child's trouble has deeply set roots in the home, especially in the attitudes of the parents. It does little good, however, to lecture the parents, give them books to read, exhort them with radio programs. The trends in the parents' personalities which are damaging their children are largely unconcious, and so deeply established that hearing lectures about how one should cope with one's children only serves to mobilize resistance and to raise further barriers against insight. For these families, the group method holds out new life-saving possibilities.

Group therapy for parents with problem children has been practiced with great success in New York, Pittsburgh, and other cities. In St. Louis a project is under way for offering group opportunities to parents in the public-school system. This is a new development based on the theory that the school has the first opportunity of any agency outside the home to

live with the child and recognize his problems. Thus the potential delinquent can be found if the teachers are alert. With care the parents can be brought into a club or discussion group tactfully enough to avoid mobilizing resentment or guilt, and in time to avert the development of confirmed delinquency in their children. This project offers a new approach to the prevention of delinquency and a new development of the group-treatment method.

Eight-year-old Mary, for instance, is an unwanted and unloved middle child in a family of three. In school she alternates between petty pilfering from her classmates and cottoning up to the teacher with such obvious need for affection that she alienates the teacher and defeats herself all around. She is acting out in school the central problem of her life at home. Mary's mother has been a member of the P.T.A. and has heard several talks on the rejected child, but it has never occurred to her that she has one at home. The group-therapy project intrigues her partly because her neighbor, Mrs. Brown (whose Willie plays truant), is going, and partly because the principal asked her to go and she wants to stand in well with the authorities. The group gives Mary's mother a complete release of guilt, since she finds that everybody else has problems with their children, too. Not only this, but being in the group gives her social satisfaction and fun. She likes Mrs. Brown and she also finds two new friends who live nearby in Mrs. Henry and Mrs. James. They all seem to have a lot in common.

It is a new idea to her that a child may steal because she feels deprived of affection at home and less loved than the other children seem to be. Mary's mother always had thought that if you spared the rod, you spoiled the child. In the opening session, she told Mrs. Brown that if Jimmy Brown were her boy, she'd give him a good licking. She hardly listened that day to Mrs. Brown's rejoinder that she'd tried that, but it didn't work too well. However, three sessions later, she did listen when Mrs. Henry mentioned that Doris behaved better for a week after her mother took her alone to lunch and the movies one Saturday. She began to see that it is possible for a child to feel so deflated that it will pick up a classmate's quarter in the locker room in order to buy the attention of another youngster; or snitch a neighbor's barrette in order to

look more appealing. When Mary's mother understands what is causing her daughter's misbehavior, she is able to temper her wrath, buy Mary a pretty barrette, and take her to see the police circus, instead of building punishment upon punishment, to the ultimate defeat of every one involved.

This change in behavior represents a change in fundamental attitudes on the part of Mary's mother. When one of the children makes trouble, mother may still reach automatically for a switch, but she's likely to wonder why the child misbehaved, too. Introspection is a new tool for living that she found out about in the group experience, and it helps her in many different situations, not only in her home. This change in fundamental attitudes can occur through other means than group techniques, but the group-therapeutic method is the surest and least expensive way to accomplish it.

Groups, of course, are no new device. As pointed out earlier, group activity really is an instinctual pattern and no normal animal lives its life out in social isolation. However, groups as formally organized instruments in our society have been largely in the hands of educators and their offshoots, the recreation workers. These group leaders approach the function of the group from the point of view of their individual disciplines. The teacher usually regards the fact of grouping, not as a dynamic tool in itself, but only as a necessary accompaniment of teaching a formal curriculum. The recreation worker may focus on a far more general approach embodied in the idea of character-building or education for democracy, but the need to inculcate certain ideas remains the same.

Since the earliest years of social work as a unified discipline, groups have been set up, discussed, and utilized. Their purposes have been many. Some were for the supervision of children of working mothers. Others were used as preventive measures against vagrancy and delinquency. The entire settlement-house development is based on the elaboration of groups as protective and developmental units.

The medical profession, however, despite certain pioneers in the field—like Dr. Joseph Pratt, of Boston, who used group methods many years ago in the Boston Dispensary for relieving the emotional problems of chronic medical patients—has lagged in its acceptance of group techniques for medical therapy. Only recently have doctors come to feel that group

living, feeling, and talking, is in itself a useful therapeutic tool in that border land between psychiatry and medicine, the psychosomatic, as well as in the frankly psychiatric and behavioral ailments.

For instance, a young woman goes to her doctor's office twice a week for six months, complaining of abdominal pain of an agonizing and crippling sort. He has examined her, has had her X-rayed, and has made a diagnosis of spastic colitis. He has treated her with a wide variety of medicines and much careful thought, but he has not been able to shake her symptoms, nor her dependence on him. Finally, in desperation, he begins sitting with her and listening to her talk. He finds that she was brought up in another section of the country, that she married two years ago and moved to her present home, that she has not been able to establish herself here with a group of friends. Further, he finds that her social adjustment was never good, and that her marriage was made in a hasty and desperate effort to solve the problem of social isolation by moving away from the locality in which she thought the problem lay.

This doctor, recognizing finally that the dislocation of his patient's life arises from her social maladjustment, sends her to a group-therapy center, this time built around an occupational-therapy unit. In this way his patient not only gets an active social experience, but also has an opportunity to learn something about the reasons for her own social failure when she sees other people in action in this controlled, laboratory situation. As she succeeds in stabilizing herself in the community through making friends with her neighbors, her tension relaxes and her gastrointestinal tract loses its emotional importance.

Thus, a group experience cures in a comparatively painless and inexpensive way some of the psychosomatic syndromes. Because this is a general part of medical lore, doctors have urged club groups, bridge parties, and so forth, on their chronic patients for many years, but there is a difference between a group for group therapy and a group like that which might meet in a night school to teach interior decorating, or the Ladies Aid meeting in a church.

This difference is based on a psychiatric approach to personality functioning. The civilized society in which we live

owes its existence to the fact that most of us can repress unacceptable impulses and use the psychic energy thus dammed up through socially acceptable (sublimatory) channels. In the normal individual, an automatic adjustment to life's requirements and society's taboos takes place and is sufficient to prevent the development of symptoms. Education has been entirely—and still is, largely—based on this fundamental principle. The normal child batters his way through the ordinary school system and learns through his daily myriad contacts how to achieve this adjustment. But the psychoneurotic child fails to develop this skill. His failure may occur because he finds contacts so painful that he avoids them, or because his impulses are so strong that he cannot deal with them by the repression-sublimation method.

When this common method of handling socially unacceptable impulses is never developed or breaks down, pathological behavior results. The therapeutic group, then, is developed on the understanding that the process must be reversed. A different atmosphere is necessary to help the sick one tolerate the strains of human contacts and thus learn to develop new attitudes toward himself and others.

If a child or a childish adult is allowed to express himself and take the consequences under supervision, he finds that less really needs to be repressed than has been locked up. The new methods of expression give acceptable and satisfying pleasure without intolerably painful repercussions. The sought-for result is a change in basic attitudes toward one's problems, medical or social, and pleasure in the sociability of the group. People develop an emotional bond because they have a common need for understanding one another and common problems.

The approach necessary to achieve this group climate is different from the approach adopted by a teacher, who is set to teach something, or even a recreation worker, set to accomplish a definite end in molding the individual's character. The therapeutic-group leader understands that the emotional giving and accepting is the therapeutic tool for achieving a modification in attitude as well as a channel for the expression of energy. Therefore, tolerance and permissiveness and relaxation of preconception are the keynotes of the successful group therapist. Any teacher, recreation worker,

or minister who is interested enough in his charges to study the problem and abrogate his own personal rigidities, at least during the treatment periods, can become a good group therapist.

It is not unusual to find that leaders of educational and recreational groups prefer to use the more controlled or disciplinary approach because they are afraid that the permissive attitudes of the psychiatrists might damage the repressive-sublimatory techniques which they believe are essential to teaching. They fail to realize that the therapeutic-group worker is interested in the use of a permissive technique chiefly when the repressive-sublimatory method has failed. Thus one hears much criticism from parents and others of the damage done by the permissiveness of progressive education in failing to teach children grammar, or the multiplication tables. In the growing-up process the matter of first importance is that the child should get along comfortably with others. Ability to parse a sentence will do him little good in the state hospital. Knowledge of the multiplication tables never kept a boy out of jail, or a man's blood pressure down. However, the normal child can be repressed and disciplined to the heart's content without harming him much. It is only for the abnormal and the ill that this therapeutic tool of permissive group living is really needed.

People can live in our society and be reasonably normal and well adjusted with complete suppression of the sexual function. But it is almost impossible for an individual to be well and happy unless he can accept and be accepted by some other members of his species. It is only lately that the therapeutic value of groups for curing ills in the social structure of the individual—and thus of his society—has been studied. But the group method as a healing instrument has potentialities that seem practically limitless now.

It has yet to be seen how widely it will be used and how the technique will be modified to solve different problems. Its success will depend in large measure on its flexibility and its capacity to meet the changing social scene effectively, as well as to adjust to the individual problems that may come within its scope.

SELF-DEMAND FEEDING OF INFANTS AND YOUNG CHILDREN IN FAMILY SETTINGS

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THE patterns for handling infants and young children that a culture evolves are an indigenous part of the culture itself. They reflect basic trends, and because of their importance in molding the individual, determine to an important degree what the evolution of the culture will be. Margaret Mead's studies of primitive societies have given evidence on these points.

At the moment we are too close to our contemporary scene to evaluate objectively what the forces molding our patterns of handling infants have been. We do know that the twentieth century, influenced by behavioristic psychology, developed a *modus operandi* that laid emphasis upon regularity in infant care. A crying infant must not be picked up lest he be conditioned to expect this presumably pleasant fondling to follow from his crying. The converse reasoning—that an infant sufficiently uncomfortable to cry needs to have the causes of his crying investigated and to receive the comfort of being fondled—was not considered. Feedings were prescribed with regularity, with little or no regard for the needs of the infant. Formula feeding was perfected, and fewer and fewer mothers nursed their infants.

A rationale for this type of handling developed. The infant's health would suffer if he were fed irregularly. The bogey of the "spoiled child" appeared, without a clear definition of a spoiled child. The implication was that any indulgence given to the child would create the need for further indulgences. Needless to say, many parents could not adhere to the letter of this Spartanlike philosophy, but they looked upon their inevitable sidesteppings as undesirable.

Writers have speculated that it was the emancipation of modern woman that fostered the acceptance of this behavior-

istic philosophy of infant care. A mother whose responsibilities to her infant could be discharged at prescribed intervals was presumably left free to follow her own pursuits at other times. There have been counterparts in history, with the tendency, particularly among upper-class women, to relinquish the care and nursing of their infants to wet nurses. Tolstoy's Natasha was unique in her society in insisting upon nursing her own children. This was not expected of women of her status.

To-day the cultural climate surrounding infant care is changing. There is recognition of the fact that infants profit by tender, loving handling and prompt response to their crying. Recent pediatric writings abound with advice to this effect. Anthropology and psychiatric theory give ground for hope that this change in handling in early infancy, accompanied by corresponding changes in other facets of the child's environment, may tend to reduce hostility and make of us a more kindly, affectionate people. Obviously such change comes only slowly.

In the area of infant feeding, the area to which this paper is directed, studies have pointed up the fallacies of many of our rationalizations regarding strict routine. Infants, when allowed to eat as much and as frequently as they appeared to indicate a desire to, have not overeaten, have not become ill, but in fact have thrived. They have not been over-demanding, but on the contrary have evolved their own feeding schedules. Existing studies represent only a beginning. There is need for extensive further research which is happily going forward.

As parents make use of this new knowledge, there will, hopefully, be a rapid decrease in the scourge of anorexia that has attacked our population of young children in recent decades. Professional people who have contact with young children and their parents know the extent of this anorexia. Psychiatric theory gives ground for hoping that this change will be beneficial to the total infant-parent relationship in eliminating a source of friction.

For my own part I have enjoyed using a self-demand feeding program with my own two infants. Fortune favored me in giving me the rare privilege of having the infants in the hospital room with me, so that I could begin this feeding

program shortly after birth. I have gained faith in the theoretical as well as practical values of this type of program as I have worked with it. The greatest satisfaction has been that of watching my own skills develop as I have handled each of my babies. For myself I found it possible to use a self-demand program and at the same time carry on the necessary operations of the household within the limits of the resources available on a middle-class income.

My own experiences gave few clues as to how a similar program would work in other families, nor had the writings of workers in the field given evidence on this point. Our culture is different from that of primitive societies, different also from that of the nineteenth century when our grandmothers suckled their infants about as often as the infants indicated an interest in the breast. Our society is dominated by the clock. Fathers must depart with regularity; older children must come and go in this same regular manner. One member of the family whose program is not governed by the clock could conceivably upset the operations of the household.

There are other important differences in our culture that may make self-demand feeding more difficult. The family group is smaller. Thus, more women must care for their families unaided. Fewer grandmothers, aunts, and grandfathers are available to help.

Housekeeping standards have risen. Young women expect more of themselves as regards the appearance of their houses. Probably they expect more for themselves. Educated and often trained for business or a profession as many of them are, it is possible that their own frustrations may mount if there is no time left for a modicum of the personal advancement to which they are accustomed.

These points and others can be raised in arguing against a more liberal, less routinized feeding program. Briefly put, the argument would be: Babies may profit by self-regulating feeding programs, but such programs won't work in the usual household because the resulting upset and confusion will be more harmful to the baby than being forced into a feeding schedule.

Is this type of argument valid? In essence, it is saying that our culture can make no provision for more relaxed,

tender care of its infant population. My own experience was, of course, subject to the criticism that it was a unique case. So I made contacts with nineteen other families, with a total of thirty children, of whom twenty-four had been raised on self-demand feeding programs. The six children not raised on self-demand programs were older siblings. The purpose of the study was simple. It was concerned solely with this question: Does self-regulating feeding stand the wear and tear of everyday living with children in our society? In a sense, the study in a humble way considers the question: What is the prognosis for a more liberalized program of infant care in the setting in which families of to-day must live their lives?

On the basis of the material obtained from interviews with these nineteen families, the prognosis appears to be good. All nineteen of the families were enthusiastic about their experiences with a self-demand feeding régime, as indicated by the fact that they would repeat the program if they were handling another child. They were enthusiastic both about the way the program had worked within the family and about the results obtained with the children. Not only the mothers liked the program; the fathers liked it, too.

Although it was impossible to select a random sampling of parents to interview, I attempted to make contacts with the parents through various sources, in order to have as broad a sampling as possible. Parents from two different cities were interviewed. Two of the nineteen families, contacts with whom were made through a well-baby clinic, were Negro families. In the end, however, the sampling was heavily weighted with professional families and with mothers who had had prior professional experience which stimulated their interest in undertaking the self-demand feeding program. This may mean either that it is this group of parents who are the leaders in undertaking self-demand feeding or merely that they came to my attention more easily.

I did not include in the sampling mothers whose reason for using non-scheduled feedings was their inability to develop a routine, and who consequently fed the baby neither according to the infant's demands nor according to the clock, but when they happened to get around to it. But I did include mothers whose reasons for undertaking a self-demand pro-

gram were spontaneous and untutored—mothers who would say, for example, "I couldn't stand to hear him cry, so I just went ahead and fed him when he seemed to be hungry."

Amazingly, some of these mothers had been able to carry on the program amid unusually difficult situations. This seemed to my mind to answer with an emphatic yes, the question, Can our society make provision for more tender, flexible care of its infant population? One six-months-old self-demand feeder had crossed the country twice and shared a one-room barrack with his parents. He had gone with them to the community dining room when they went to take their meals. The mother had varied from the baby's self-demand schedule only to the extent of feeding him early on occasions when she foresaw that he would be hungry at a time when she would be unable to feed him. Three of the mothers had been able to nurse their infants on a self-demand schedule and simultaneously carry on at least part of their former professional life. One mother whom I observed combined office and home. At the time that I saw her, she was nursing her third child. She had developed the ability to slip away from her office and its demands, nurse her baby, then nine months old, and return to the office.

The largest number of mothers, sixteen, were giving their major attention to home making and most of them were regularly doing their own housework. The ability and insight reflected by the accounts of some of the mothers give cause for rejoicing. One mother, whose youngest child was remarkable for the frequency of his feedings on his self-demand schedule, did her own work and cared for her two-year-old daughter. "My frequent nursing of the baby never seemed to make her unhappy. She had her doll play and did for her doll exactly what I did for the baby. No doll was ever nursed so much."

This account contrasts with the frequent reports that one hears in clinical practice of mothers who give as their reason for abandoning nursing the jealousy of an older child. Aside from the generally good relationship that existed between this two-year-old and her mother, the fact that the older child had herself been favored with a long nursing experience on a program of self-demand feedings may have been

a contributing factor in this lack of jealousy and ability to identify with the mother.

Each of these nineteen mothers was very different from all the rest, evolving her own family life in accordance with her personality, her varying resources and equipment. They were so different as people that I completed the interviews with the conviction that this self-demand method of feeding could probably be carried out in a high percentage of families. However, more than half of the mothers interviewed did not share my conviction, feeling that many mothers would encounter difficulties in going against current practice in infant feeding, or would be disturbed by the lack of routine. One mother felt that it might not work with all children—that her older child appeared to profit by routine and by having her time more planned. The mother had not attempted to use self-demand feedings with this child. Professionally trained mothers were less sure about how the program would work in other families. Mothers who had undertaken the program because it seemed to be the natural thing to do, because the doctor recommended it, or because they did not like to hear the baby cry, mothers lacking theoretical convictions, were in general of the opinion that the program would work in the same simple way in other families as it had in their own.

Gesell's and Ilg's reports on self-demand feeding, the accounts of pediatricians, and my own experience with my two youngsters had established the fact that infants will spontaneously evolve a flexible schedule. The reports of the mothers whom I interviewed substantiated these previous findings. I came to think of this spontaneous scheduling as a process of mutual adjustment between the infant and the household. Some mothers spoke of the fact that the baby seemed to be wakeful and to demand frequent feedings during the evening, often saying in this or another connection that they and their husbands enjoyed having their babies with them at this time. Other families said that the program of self-demand feeding did not prove to be overtaxing because the infant at an early age could be relied upon to settle down for a night's sleep in the early evening, thus giving the parents time off.

There were similar differences in the extent of irregularity in the schedules and in the age of the infant at the time that he evolved a schedule. One is tempted to speculate as to the factors that cause these differences: basic physiological differences in the babies themselves, differences in the food available to the infant—*e.g.*, bottle milk as contrasted with breast milk and varying supplies of breast milk—coupled with differences in the handling by the parents and in the judgments as to when a feeding is indicated. But according to the reports of the parents, all of the infants had evolved a schedule sufficiently regular for the practical operations of the household by the fourth to fifth month of life. Most of the infants evolved a schedule framework earlier than this, during the second to third month of life.

The mothers indicated that they found it possible, during the early weeks of the infants' lives, to adjust to the irregular schedule without undue upset. As one mother put it, "When a baby is so young, you don't expect to go out anyway." Thus for these nineteen mothers whom I interviewed—mothers who had raised a total of twenty-four children on self-demand feeding schedules—this method of handling feeding had proved feasible within the cultural framework of to-day's home.

Critics of self-demand feeding have suggested that the method might become a fetish, tending to attract neurotic mothers who would enslave themselves to the baby's whims. I found no indication of this among the limited number of mothers whom I interviewed. When there was an urgent reason for having the baby fed by a certain time on a given day, they were able to accomplish this without upset to themselves or to the baby, according to their reports.

Does a program of self-demand feeding make it more possible for a mother to breast-feed her infant successfully? Further research around this point is needed. All too little is known about the factors that make for success or failure in breast feeding, and the evidence surrounding the importance of the sucking of the infant is conflicting. Of the twenty-four children considered here, sixteen had been breast-fed for four months or longer. Why this unusually high incidence of breast feeding? I gained the impression in talking with these mothers that they were, as a group, unusually interested

in family life. Would one expect a higher percentage of breast-fed infants in this group in any event?

One case of breast-feeding was remarkable. During the hospital period, the infant received a negligible amount of breast milk. On the sixteenth day of life, when he was brought home from the hospital, he was placed on a self-demand feeding régime and efforts were made to keep supplemental bottle-feedings at a minimum. One day he took as many as eleven feedings. After ten days on this régime, he was entirely, or almost entirely, breast-fed. The mothers spoke of the profound pleasure they received from nursing their infants, and I was made aware repeatedly of the strength of the tie between the mother and her nursing infant. Surely this experience means as much in the emotional life of the mother as it is believed to mean in the life of the baby.

What happens to these self-demand feeders as they begin taking foods other than milk? The much-quoted studies of Davis, carried on with children in an institutional setting, have suggested that children, when presented with a selection of nutritionally desirable foods, will make a choice of foods that will maintain them in good health. The selection at a given meal or for a given period of time may be highly unconventional. Of the children considered in this study, twenty-one were having solid foods. I was surprised to find great variation among these parents in their methods and their philosophy of handling solid feedings. One family believed in a program of urging food.

The interviews pointed up the difficulties in the situation, particularly when the children became old enough to forage about the kitchen for themselves or to eat with the family. It can scarcely be hoped that a young child will make a nutritionally good choice of food from the table set for adults in many households. Either the adults must be willing to change their food habits—particularly their use of sweets and confections—or restrictions not in line with a philosophy of self-demand feeding must be set up, or the infant must be allowed to consume a diet less than optimum. The interview material surrounding the handling of solid-food feedings indicated that the parents had a less clearly defined philosophy regarding the handling of these feedings than regarding the handling of breast or bottle feedings. Each family was work-

ing out its own methodology, setting up some restrictions upon the child, changing the diet of the family, or allowing the child to eat some foods not considered desirable, with varying emphasis upon one or another method, depending upon the subtleties of parental decisions. Clearly there is need for further research that will give guidance to families as they make these decisions.

Obviously no sweeping generalizations regarding the workability of self-demand feeding can be made from a study of nineteen families. Coupled, however, with reports from the literature, the study seems to warrant the statement that a large number of parents in our society are currently finding it not only feasible, but satisfying, to employ this method of feeding within the cultural framework of our family living of to-day. Whether or not this method of feeding will replace the more rigid methods of the early decades of this century will be decided in the future. There is ground for hoping that these more flexible methods will contribute to the emotional well-being of parents and children, and that these methods may make it possible for more mothers to breast-feed their infants. Further research, it is to be hoped, will throw light on many of the questions and problems concerning which our present information is meager.

PSYCHIATRY AND GENERAL MEDICINE *

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GENERAL medicine has discovered psychiatry! It may be that this statement is a bromide, or it may be merely the self-deception of an enthusiast. I think, however, that it is probably a fairly accurate statement of the truth. But why should it have been necessary to wait so long for such a discovery? Certainly there is nothing new about mental disease. We read about it in the early books of the Old Testament and in the Egyptian papyri. Literature is filled with references to it, we read of its victims in the daily press, and to-day there are well over half a million patients under treatment in mental hospitals. It would seem—would it not?—that we might reasonably have expected this discovery to have taken place much earlier than it has. As a matter of fact, though, this late arrival of psychiatry upon the medical scene may not be quite so strange as appears at first glance.

From the time of Galen until the time of Pinel, mental disorder had been almost entirely outside the ken of the medical man. Such attention as was given to the mentally ill was provided by the minions of the law or by the church, and discussion of what to-day we should call mental mechanisms were carried on by the philosophers. Pinel's titanic step in striking the chains from the patients in the Bicêtre has tended to cloud the medical significance of the man. It was he who wrote what may to-day be considered the first systematic treatise on mental disorder, the work entitled, *Medico-philosophical Treatise on Mental Alienation,* published in 1801. In the history of mankind, and indeed in the history of medicine, this date is recent.

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Esquirol and Georget, who succeeded Pinel in France, and our own Benjamin Rush were, first of all, physicians, and it is not strange that they searched largely for physical causes of mental disorder. Rush, for example, writing in 1812 the first book on mental disorder published in the United States, placed the primary seat of madness in the blood vessels, although he added: "This predisposition extends to the nerves and to that part of the brain which is the seat of the mind, both of which, when preternaturally irritable, communicate more promptly deranged action to the blood vessels of the brain."

Both he and Haslam, who was writing in England at about the same time, laid great stress upon the importance of bleeding, blistering, purging, and emesis as modes of treatment of mental disorder. There were those, including Haslam, Pinel, and Esquirol, who likewise emphasized what they termed "moral treatment"—that is, what we should term to-day "psychotherapy."

A search for physical causes logically led to the trial of physical remedies. As early as 1781, we find a record of convulsions due to camphor as being efficacious in certain psychotic reactions. Perhaps convulsive therapy is not quite so new as we think! On the whole, however, it is not strange that with the failure to find startlingly effective physical methods of treatment, the interest of medical men in the subject of mental disorders waned.

This waning of interest was accelerated by the establishment in the United States of the mental hospitals or, as they were called in the early days, asylums. It is of interest to note that the Eastern State Hospital at Williamsburg, established in 1773 as the first public mental hospital in the United States, was for nearly seventy years in charge of a "keeper" rather than a physician. These institutions were intended, as their early name implies, as places of safety, but the safety emphasized was that of the public rather than that of the patient. They were organized as adjuncts to the police power. The "furiously mad" were sent to them, and that other, almost equally unfortunate group of persons—the "pauper insane." It should be remembered that in those days pauperism was looked upon as essentially an offense against the public, and the stigma attaching to it was almost as great as

that of crime. The medical and curative aspects of these institutions were apparently secondary; some occupation was prescribed, but the rôle of treatment was slight and casual.

The historical development of our mental hospitals sheds considerable light upon their present unhappy plight. Originally established as charitable institutions, they have in almost all of the states of the Union continued to be administered by the state agency that is primarily responsible for the care of public charges. Nowadays, this is usually referred to as the department of public welfare, as is the case, for instance, in the Commonwealth of Pennsylvania. In some jurisdictions, it is known as the board of control. With the exception of those very few states that have established medical supervisory organizations, such as the Massachusetts Department of Mental Health, the mental hospitals of the United States are still operated by departments that have what might be termed the "public charity" point of view.

This means that the appropriations for the mental hospital are likely to be considered along with those of reformatories and prisons, state infirmaries, and other non-medical institutions. Had the mental hospitals of this country been administered by state departments of health rather than by state departments of public welfare, it is quite likely that the appropriations for their maintenance and support would have been much less niggardly. We are now seeing the results of a long period of slow starvation reflected in ways that have been well publicized in recent months—overcrowding, deferred repairs of plant, inadequate and underpaid personnel, insufficient clothing and feeding of the patients, not to mention their strictly psychiatric and other medical needs.

The institutions that were built during the last century and even some of those built since 1900 were located, in general, in isolated areas, but their isolation was more than geographical. They were looked upon as outside of the stream of medicine, and their physicians were regarded by the doctors in the community as some "lesser breed without the law." The effect of this professional isolation was felt in the instruction given in medical schools, and the neglect of psychiatric training in medical schools has in turn made it increasingly difficult to secure medical men of the proper caliber to man the hospitals.

Thus we find ourselves in a vicious circle. This is particularly unfortunate in view of the fact that mental hospitals are and probably always will be of great value as potential training centers for psychiatrists. This fact, recognized years ago by William James, finds expression in the current requirements for the American Board of Psychiatry and Neurology. James, in his significant volume, *The Varieties of Religious Experience,* published in 1902, had this to say about the study of the frankly pathological:

> "Insane conditions have this advantage, that they isolate special factors of the mental life and enable us to inspect them unmasked by their more usual surroundings. They play the part in mental anatomy which the scalpel and the microscope play in the anatomy of the body. To understand a thing rightly, we need to see it both out of its environment and in it, and to have acquaintance with the whole range of its variation."

All too many of the medical officers who returned from the services imbued with an interest in psychiatry were inclined to spurn the training possibilities of the state hospitals. Granting that many state hospitals leave much to be desired in the line of adequate staff interest in training and in suitable facilities for such training, the fact remains that, useful as are didactic lectures and didactic analyses, valuable indeed as are out-patient departments, they are hardly by themselves satisfactory substitutes for a period of close observation and study on the wards of a mental hospital.

I have emphasized some of the desirable and some of the undesirable features of our mental hospitals in an attempt to explain why a real incorporation of psychiatry with medicine has lagged. It has lagged. The psychiatric pavilion of Albany Hospital, opened in 1902, was for a long time practically the only psychiatric pavilion in a general hospital in the United States, with the possible exception of Bellevue in New York and Cook County Hospital in Chicago. It is doubtful if, even to-day, there are many over one hundred such psychiatric facilities in all of the general hospitals in the United States.

One reason for this has been the force of tradition, which, in spite of the fact that the United States is a relatively young country dedicated to the abolition of some of the Old World traditions, is still strong. There has been, in general, a strong social disapproval, not only of mental disorders, but of tuber-

culosis and other contagious diseases. In the case of the two latter, this prejudice has been very substantially broken down, especially as the general practitioner and the internist have obtained in their medical training some knowledge, at least, of the treatment of these types of disorder.

There has remained, however, in the mind of the internist a fundamental consciousness of ignorance of mental disorder. There are still many otherwise competent practitioners who admit that they know nothing about mental disease and its treatment and who, strangely enough, admit it with a certain degree of pride rather than of shame. There has been, perhaps, a certain amount of rivalry—fear on the part of the internist that he would lose the patient to the psychiatrist, and failure to recognize the fact that he is the one who should know how to handle most of at least the simpler psychiatric problems himself.

The old tradition that mental disorder is something to be cared for only in mental hospitals has been weakened substantially by several relatively recent developments in medical theory and practice. Foremost among these, of course, is the work of Sigmund Freud and the light that he cast upon the entire problem not only of the psychoses, but of the neuroses, and the rôle of the unconscious in the causation of various symptoms, mental and otherwise.

These discoveries were corroborated not only by the work of Sherrington and his associates on the integrative action of the nervous system, but by that of Cannon, Bard, and others of the physiological group on the direct effects of various emotions upon the physical organism. Synthesizing these points of view, White and Meyer emphasized the necessity of the organismic approach—the dealing with the patient as a person and not as a congeries of ailing organs.

This concept, although it had had occasional precursors, even as far back as the time of Aristotle, has been recently popularized under the term "psychosomatic medicine," thanks especially to Dunbar's work and more recently, among others, Alexander's and Harold Wolff's. Much was said about this term during the war, and even more recently one of our weeklies of wide circulation devoted several pages to a "popular" treatment of this concept of medicine.

The term is in some ways a singularly unfortunate one.

It tends to promote the conception of a dichotomy between the psyche and the soma, a dichotomy that all our psychiatric teachings repudiate. It even seems to set up as a specialty of medicine what should be an underlying approach to the entire practice of that profession—namely, that of considering the patient as a person. The term "comprehensive medicine," as used by Wortis, is in many ways more satisfactory—in the first place, it is plain English!

After all, what is termed psychosomatic medicine to-day is rightly nothing but a rediscovery of the truth that was known to the general practitioner of a hundred years ago—namely, that he could not treat an illness without knowing a great deal about the patient he was treating. It is sometimes salutary to be reminded that what we think new may be really ancient; such is the case with the term we have just mentioned.

Zilboorg has recently brought to notice an interesting publication which appeared for one year only in Berlin in 1838, under the editorship of Maximilian Jacobi and Friederich Nasse, physicians who were interested in mental disorders. The first two articles use the word, "somato-psychic," in the title, and the reverse form, "psychosomatic" *(psychisch-somatisch)*, is found in the text quite interchangeably. In the first article (by Nasse), we find this statement: "The business of recognizing, preventing, and treating conditions of mental disorder [*Irreseyn*] rests upon the fundamental investigation of the simultaneously psychic and somatic activity of man. Here it finds its scientific support, from here on it gains light and learns the road."

Fundamentally, the term was intended to convey two things, at least: first, that illness, primarily somatic in type, inevitably produced psychological repercussions in the patient; and, second, that emotional disorders may be primary in setting up a number of very troublesome symptoms referable to the soma. In other words, the term should mean that no disease is either wholly somatic or wholly psychic.

Psychosomatic medicine, if it is to be set up as a specialty, would certainly seem to be fully as much within the ambit of the internist as it is of the psychiatrist—indeed, probably more so. Certainly there is nothing in the training of the psychiatrist as such which makes him an expert on

internal medicine. He should know much more about internal medicine than most psychiatrists do, although he is quite ready to criticize the internist for not knowing more about psychiatry. Indeed, I am inclined to think that psychosomatic medicine is far more properly a specialty of the internist—if, indeed, it be a specialty at all. I agree fully with Alexander in his view that the term is properly used as "referring to a method of approach in research and therapy, a method which can be applied in the whole field of medicine."

Some psychiatrists in recent years, perhaps imbued with an undue enthusiasm for what they look upon as a new discovery of their own, are perverting the term, "psychosomatic medicine," by using it to refer almost exclusively to conditions essentially of a psychogenic nature. A drug psychosis, a delirium or other psychotic episode following childbirth or a surgical operation is as much within the field of psychosomatic medicine as is the so-called "organ neurosis," a term in itself open to many objections.

A corroboration of this statement is found in Stanley Cobb's article, "Psychiatry in a General Hospital," as reported in the *Bulletin of the New York Academy of Medicine* for March, 1946. Cobb found that out of 269 patients on his closed ward at the Massachusetts General Hospital, 64 were suffering from a medical condition with delirium, 52 from drug psychosis, and 31 from a surgical disease with delirium—a total of 147, or 54 per cent of all the patients in that group.

Psychosomatic medicine should imply a meeting of minds, not rivalry. It should represent the approach of medical men to the problem of the sick person, not overlooking the possibilities either of organic disease or of psychogenesis; not neglecting, on the one hand, the psychological complications of organic disease or, on the other, the possible structural implications of the psychically conditioned disorder.

There is unquestionably an increasing interest on the part of general medical men in the psychological aspects of their patients and, largely due to the impetus of World War II, there is a vastly decreased resistance on the part of physicians and public alike to psychiatry, and a recognition of the treatability and curability of emotional disorders. The returning veteran has very little hesitation now about con-

sulting the out-patient department for symptoms that are essentially neurotic and that he understands to be emotionally caused. This is a healthy sign, and it is probably to a large extent basic in the increasing readiness of general hospitals to provide facilities for the cross-fertilization of their psychiatric and other medical and surgical staffs by the establishment of psychiatric facilities within the hospital.

Heldt, who has had a long and fruitful experience at the Henry Ford Hospital, points out that psychologically it is highly desirable not to have these facilities in a separate building even if connected by a bridge. They should be an integral part of the hospital. The internist should be welcome in the psychiatric facilities, and the psychiatrist should make rounds on the medical and surgical wards.

The psychiatrist is a physician; let us constantly remember that. He is not to be merely tolerated, called in when a patient "blows up." He can contribute greatly to the understanding of the obscure medical and surgical patients, the unduly prolonged convalescences, the patients who are uncooperative or resistive, just to cite some of his possible functions. His colleagues will find that he can be of real help to them as a day-to-day co-worker; they will find, too, that their view of the patient as a whole, their readiness to recognize emotional problems and to deal with them, will make for more effective care of their patients. In short, each specialty can, as indeed it should, aid the other.

Again, emergencies will arise from time to time that all too often to-day are "solved" by removing the patient, perhaps at considerable physical risk, to some remote mental hospital. I fail to see how any hospital can call itself "general" that is not equipped to see the patient through, whether he need an operation or whether he develop an acute delirium in the course of some other illness. To my mind, any general hospital to-day that is not provided with psychiatric facilities for the adequate care of acute psychiatric emergencies—including, by the way, acute alcoholism and delirium tremens—is far behind the procession of hospital construction and administration. It is high time that "general" hospitals ceased to partition the patient; they should at last treat the whole man, not just his physical complaints.

The Veterans Administration has set a salutary example

in arranging to have its future hospitals general, with facilities for medical and surgical, psychiatric, and tuberculous patients. It is doing much in its training and hospital programs to raise the standards of medical care, and much credit is due to General Hawley, Chief of the Bureau of Medicine and Surgery. The federal government, both in its general-hospital construction program and in the program of the Institute of Mental Health, is encouraging the development of psychiatric facilities in general hospitals and will aim to raise the standards of the state hospitals, not only in the care of patients, but in the development of the hospitals as centers of training and research.

The future is bright, indeed, for psychiatry, not only as a specialty in itself, but as a catalyzer and close associate of the other specialties in medicine.

PSYCHOSOMATIC IMPLICATIONS IN CARDIOVASCULAR DISEASE *

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IN the weeks since I accepted the invitation to share in this discussion by remarks on the psychosomatic aspects of cardiovascular disease, I confess I have experienced many moments of trepidation. For I am neither a psychiatrist nor a student of psychosomatic medicine and I am not a heart specialist. I am in the practice of internal medicine, trained in the school of organic diseases; for three years a pathologist, spending my time at the autopsy table; and beginning the practice of medicine with the conviction that each patient I would see would have physically demonstrable disease of one or more of his organs or systems.

But it has come to me that not all early convictions have been borne out by the passing years. I began to remember the patients with organic disease whose illnesses were complicated by social, domestic, and personal problems, or by variations in their own personalities. Indeed there have been times, troublesome to my mind, when an autopsy failed to show satisfactory explanation of the patient's symptoms or even occasionally the actual cause of death. I thought, too, of many individuals examined in whom no organic disease could be demonstrated, yet who were not well and who needed help.

Thinking thus, I decided that perhaps the best way to present the subject was in a series of selected case histories, to illustrate some of the psychosomatic problems that accompany heart and vascular disease. No doubt my evaluations of the life situations of these individuals as related to their illnesses would seem superficial in the eyes of the trained psychiatrist; certainly it has often not been satisfactory to me. And as the following histories will show, even when the life situation is readily recognizable, it is often no more amenable

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to complete correction than are many organic changes of the body with which we as physicians are called upon to deal.

We were recently consulted by a woman of forty-eight who complained of shortness of breath, pain under the left breast, and fear of heart disease. The only other symptoms were nervousness, sleeplessness, and some recent irregularity of the menstrual cycle. She stated that the family relationships were good, although her husband "drank a bit."

She was an apparently stable Italian woman whose sole abnormal physical sign was a rapid pulse. Blood pressure, basal metabolism, electrocardiogram, and urinalysis were normal. From a purely physical standpoint, the diagnosis was incipient menopause, and we were about to reassure her and prescribe for the menopausal manifestations when something prompted us to ask more about the husband who "drank a little."

With outward evidence of emotion, she then told us a story of heavy drinking and abuse from the husband from the beginning of her marriage, at eighteen years of age, until the past year, when, under threat of divorce, the husband had begun to treat her with more consideration. But during the same time a son had returned from the army with what she called "bad ways." She would say no more at that time. Reassured as to the absence of heart disease and given a mild sedative, she was sent home, but returned in two weeks unimproved.

Further conference now revealed that the son was completely disrupting the family life with arrogant bursts of temper—actually throwing the household goods about when he could not find what he wanted—and boasts of burglary. No practical solution of this problem seemed possible. We advised her to take a firm stand with the son, as she had with the husband, but this she said she could not do because she feared physical violence from him.

At this interview, even more of her background emerged. She voluntarily told us that her son and her husband told her that she was "too damned nervous—she had better go see a doctor." On her fourth visit, she told us that her married life, even without the problem of drinking, had always been unhappy and that she had never loved her husband. When asked why she had married him, her reply was, "Why, I wanted a pretty white dress and a wedding like the rest of the girls—

and besides my mother had too many daughters and had to get rid of them." As she said this, she placed her hand over her heart, gave a series of deep respirations, and tears came to her eyes. "You see," she said, "that's how short of breath I am."

It is worth noting that only after repeated visits did even a partially complete picture of her life situation emerge—a crowded home in childhood where daughters must be married off to relieve the economic situation, a romantic desire for a pretty dress and a wedding, a loveless marriage with abusive drunkenness from the husband, and a behavior problem of a son. Apparently she was able to cope with all this until two new factors entered her life—(1) the beginning of the bodily readjustments of menopause and (2) the return of the unruly and inconsiderate son. Because of fear of making the situation worse, she has refused to let us talk to the husband and son, so that to date all we have been able to accomplish is to relieve her to a degree of her anxiety with regard to serious heart disease, try to help her medically with the menopausal situation, and allow her the benefit of "mental catharsis" in discussing her problems with us. While such therapy is far from solving her difficulties, she is already feeling much better—for the time being at least.

Many other examples of fear of heart disease could be cited from the files of any physician. In adults this usually takes the form of aching or stabbing pain over the heart (not the crushing substernal pain of coronary occlusion), or of a sighing type of respiration which is interpreted by the patient as true shortness of breath, or of swelling.

A single woman of thirty-two was seen because of recurrent swelling of ankles and of headache. She feared that either her heart or kidneys were failing. Physical and laboratory findings were normal. She at first denied any periodicy of the swelling, but when asked to watch it over a period of three months, she reported that this and the headaches came on about a week before the menstrual period and left rapidly thereafter. This common phenomenon in younger middle-aged women was explained to her as well as its cause—that is, pre-menstrual accumulation of body fluids and not heart or kidney disease. Appropriate limitation of salt and fluids and a

diuretic were prescribed, with the expected relief both mentally and physically.

The question of the significance of cardiac murmurs with or without preceding rheumatic disease is frequently raised either by young adults or by the parents of children. The fear of such murmurs is frequently exaggerated by the physician's attitude—either by undue warning or by too frequent or too prolonged examination of the heart. With patients already aware of such a murmur, but showing no signs of significant disease, it seems wise to us to admit the presence of the murmur, but to assure the patient that such a murmur is not incompatible with a long and active life. With persons not aware of their murmur, it is not necessarily the physician's duty to inform them of it, as most of such murmurs are of no clinical importance and the knowledge of their presence may only lead to a cardiac neurosis. But perhaps it is better even here to let the presence of the murmur be known and its lack of importance emphasized, since these young people will be frequently submitted to routine physical examinations and probably learn of the murmur anyway.

Even in the presence of structural heart change of rheumatic or congenital origin, we do not believe that undue pessimism should be expressed. The following three case histories may illustrate this point.

A young married woman was referred to us about fifteen years ago in the third month of her first pregnancy. She had marked, but well-compensated mitral stenosis. Fear of the effects of labor and of future pregnancy led the patient, her husband, her obstetrician, and myself to agree on Caesarian section at a little before term and section of the Fallopian tubes to prevent further pregnancy. When seen recently, this patient was in robust health, still with her mitral stenosis, but without any signs of further cardiac damage. She is allowing herself to become so stout that I fear the burden of obesity is a far greater hazard to her circulation than the old pregnancy.

Another young woman whom we had treated for rheumatic fever at sixteen years of age and who also developed mitral stenosis, was seen at twenty-two years of age in the sixth month of her pregnancy. A combination of our greater faith in a good myocardium and of her own religious beliefs permitted

her to go to term and spontaneous delivery not only of that infant, but of a second. When seen less than a month ago, she was in excellent health.

Again under rheumatic disease is the story of a man of thirty-five, the fears of whose previous physicians had interfered with the proper management of his problem. He had known of a "leaking valve" since he had had rheumatic fever at fourteen years of age, but had worried little about this, had married and had a family. His work as a machinist gave him no discomfort and there was no shortness of breath even on reasonably heavy exertion. But he had recurrent abdominal pain. On two occasions this was interpreted as appendicitis and treated with ice caps and rest, as his medical attendants told him that his heart was "too bad" for an operation.

The attacks of abdominal pain continued and for the first time this man began to worry about his heart. When seen by us, the abdominal pains had incapacitated him for work and he was very much depressed because he felt that his heart was so bad that nothing could be done for him. He actually did have marked hypertrophy of the heart, with both mitral stenosis and aortic regurgitation. But what was causing his pain was a right inguinal hernia which was at times becoming incarcerated.

In spite of the marked valvular changes, the heart muscle seemed to be doing its work well, so, with some misgiving, we persuaded the patient and a surgical colleague to have the hernia repaired. He went through the operation easily and has been free of pain and anxiety and back at his regular occupation for many months.

Our chief concern now is to keep him within the limits of reasonably safe physical activity, at the same time avoiding advice that might lead to a return of his depression concerning his heart disease. Almost certainly within the next decade he will suffer circulatory breakdown, but in the meantime he has been relieved of intolerable and incapacitating pain and a state of serious depression, and has resumed the support of his growing family.

In contrast to this patient let me cite another—a man of fifty, also with organic heart disease, who has been followed for several years. He complains of shortness of breath, anxiety about heart trouble, and a heavy aching in the region

of the heart. He has read a good deal about heart disease and on several occasions, when he has had a simple bronchitis, has told us that he was surely developing edema of his lungs from a failing heart. He does have evidence of cardiovascular disease in the form of hypertension and electrocardiographic evidence of a bundle-branch bloc, things of which he is aware and which he fears constantly. Although his physical state is stationary, he demands repeated examinations and heart tracings in order to be reassured that his disease is not advancing. After such an examination he carries on at his work as a professional man for some time until panic again seizes him and he returns for further examination and reassurance.

It has long been our opinion that, even in the face of organic disease, this man is capable of a reasonably normal existence were he to reduce his weight and cease his constant worry. The former he does not do because of lack of will power to control his appetite, and the latter seems impossible to him. Constant reassurance of the stability of his heart lesion seems to be the only solution we have been able to achieve.

A contrasting psychosomatic problem is that of a colleague of the last patient, a short, stocky man of fifty-two, who four months ago suffered a coronary occlusion with classic clinical and laboratory findings. He is a man of unusual nervous stability and personal ability to coöperate with his physicians. He was told frankly what had happened—that it meant at least a month's rest in bed and two to three more months of modified rest at home, but that he could hope, barring the unforeseen, to return eventually, with certain restrictions, to his normal occupation.

This man grasped the situation and did exactly as he was told, and a month ago returned to his office. He knows what has happened and knows the possibility of the recurrence of the occlusion, but prefers the added risk of work to a life of idleness, after being informed that even with complete retirement we could not promise that another occlusion might not occur. This man is dynamic and efficient and one on whom others are prone to unload their responsibilities because of his natural good will and desire to take part in daily living. We believe, however, that we have chosen the

better way for him, since we are both agreed that chronic inactivity would lead to great unhappiness.

Almost the exact opposite is illustrated by the story of a man of fifty-seven who about three years ago suffered an occlusion of almost the same degree of severity. He, however, not only had the pain of his occlusion, but during the first part of his hospital stay lay almost paralyzed with fright. In addition to his physical findings, we learned that he was the owner of a small, but profitable business and that he was very resentful because his two sons, his partners, neglected it, leaving this burden upon his shoulders.

He made a good physical rceovery, but remained extremely apprehensive and was with the greatest difficulty persuaded to get out of bed after more than six weeks. He remained in the hospital for about three months, during which time we found ourselves filling out disability-insurance papers against several large companies—in fact, enough to assure this patient a more than ample livelihood if he never worked again.

He finally felt well enough to go to Florida for the rest of the winter and spring and, when seen on his return, was in excellent physical condition, but constantly fearful of another attack.

Giving him the benefit of the doubt, we subscribed to further disability throughout the coming year, at the end of which he was asked by one of his insurance companies to appear elsewhere for examination. This he did and was also seen by us and further studies were made. Both the consultant for the insurance company and we ourselves considered this patient capable of returning to light work, and he agreed to try it. But on his return home from our office to a nearby town, he was seized with severe precordial pain and placed in bed by his home physician. The latter in great anger called us and told us bluntly that this man should never have been encouraged to work again and that we had done him great harm by suggesting it.

Perhaps we did. Perhaps we should have recognized that the escape from business conflict with his sons and the comfort of an assured income from disability insurance could not safely be taken away from him. We are naturally no longer taking care of him, but when last heard from, through

relatives, he was again enjoying the comforts of retirement in Florida.

Arterial hypertension is a problem that one encounters daily in the practice of internal medicine and the reactions of individuals differ with personality. There is a woman in her late seventies whom I have followed now for seventeen years. Her systolic pressure during all that time has been well above 200 and the diastolic has never been to my knowledge below 120. She has gone through one major cerebral hemorrhage, the loss of a favorite son, and a fractured hip. While she says she worries a great deal about her blood pressure, she eats enormously, enjoys a cocktail or dinner party with her friends, and is a most humorous and delightful patient to visit. The joy of living is in her and I believe will remain until her final stroke occurs.

How different is she from the worrying individual who returns again and again to the office to have her blood pressure taken. I have often wondered how much influence the expression, "blood pressure *taken,*" has on the psychic reaction of most individuals, and have been tempted to run a parallel series, in which I would say, "I will now *determine* your pressure," to one group, and, "I will now *take* your blood pressure," to the other. I have a feeling that the group in which one *"took"* the blood pressure would do better than those in which it was merely "determined." The very word *"take"* implies that one is removing some of the pressure and may constitute a legitimate form of psychotherapy.

Better yet, to my mind—until we are able to control hypertension in some measure—is it to say at the beginning, "You have some rise in blood pressure—many people have. Your headaches are probably due more to anxiety about this than to the hypertension itself. Try to learn to live with it as reasonably as possible." And take the blood pressure thereafter only when some clinical change indicates it.

This of course does not hold for the young person with malignant hypertension or advancing glomerulo-nephritis, where active and sometimes heroic therapy may be needed to relieve distress. What I am referring to above is that vast host of persons in the latter decades of life with moderate hypertension who wander from doctor to doctor seeking a

cure and who live in daily dread of a stroke or invalidism. To a certain number of these individuals such a time will come, but in the meantime, is it not wise to direct their attention away from the hypertension into more productive or amusing channels?

Here may be a field for the occupational therapist who, instead of devoting her time exclusively to chronic institutional patients, might utilize her talents in training people in a variety of hobbies and craft work. As a matter of fact, most of these hypertensive individuals and persons with organic heart disease need not or cannot depend on hobbies, but with proper advice and care are able to continue their normal occupations for long periods of time.

I have in mind a woman of fifty-five who was first seen two years ago this month, with complaints of breathlessness, palpitation, and wheezing at night which so interfered with her sleep that she had given up her occupation as a comptometer operator. She was a widow and the chief support of her family so that the loss of income gave her almost as much concern as did her physical symptoms.

Examination showed advanced hypertensive heart disease, auricular fibrillation, and all the signs of congested heart failure. Rest, digitalis, and graded return to activity restored her cardiac compensation, and, being a rather unimaginative individual, she resumed her regular work without much evidence of apprehension. Eventually the heart rhythm restored itself to normal and she herself stopped her maintenance dose of digitalis.

In November of 1945, her sister, who lived with her, was found one morning dead in bed, presumably of coronary occlusion. When seen a few days later, the patient was again fibrillating and breathless, but redigitalization, reassurance, and a brief period of rest soon restored her to a state where she could resume her job. She continues to fibrillate, but remains in good health; to us, surely, a better present situation, regardless of future difficulties, than a life of invalidism and dependence upon charity. An explanation to her that her type of heart disturbance had little likelihood of ending in sudden death, like her sister's, seems to quiet her apprehension.

An interesting side light on this patient's story has to do with her daughter. This young married woman came to us also within a few days of the sudden death of her aunt. She was nervous, short of breath, had pain under the left breast, and feared serious heart disease. Flushing, lacrimation, sighing, and other positive evidences of emotional instability were noted at the first consultation, but physical evidence of heart disease or other organic change was entirely lacking.

Further questioning soon brought out the fact that while her complaints were much worse since the sudden death of her aunt, the emotional disturbances had long preceded this. Because of economic difficulties and inability to find proper housing, she and one of her children were living with the mother and aunt, while the husband and other child were making their home with his parents. A flat statement to her that she had no heart disease, but that her symptoms were due to unsatisfactory living conditions, plus the shock of her aunt's death, led her and her husband to find an apartment where the family life was restored. She has improved greatly, but returns from time to time with recurrence of symptoms and fears, requiring further reassurance.

Such, then, are some of the personal and emotional problems seen by any physician in people with real or imagined heart disease. While a few of these may be of sufficient severity to demand specialized psychiatric treatment, the vast majority must continue to be handled by the general physician. There is nothing new about these problems themselves, except perhaps their increasing incidence. Our predecessors in medicine were well aware of them, perhaps more so than we who, interested and at times confused by the increasing complexity of the medical sciences, may lose proper perspective and forget that we are dealing with people and not with diseases.

As preventive medicine and specific treatment of the acute diseases leads us more and more toward an aging population, the incidence of hypertensive and degenerative cardiovascular disease continues to increase. Whether or not the tension of modern high-pressure living causes, directly or indirectly, disease of the heart or of the blood vessels, I am not prepared to state. Certainly the radio, the public press, and the popular magazine are increasing the population's

awareness of health problems, at the same time often unfortunately leading the laity to expect more than the medical profession can offer them.

If we are truly to help these individuals, it behooves us as physicians (1) to acquire in medical school or through reading and experience at least the fundamentals of psychology and psychopathology, and (2) to interest ourselves not only in the patient's organic disease, but also in his personal and occupational background, adjustment problems, fears, and also his recreational opportunities and preferences. The help of the psychiatrist, the social worker, and the members of the patient's family may often be needed. For though we have no specific cure for many of the disease states of the cardiovascular system, it is our feeling not only that certain drugs may alleviate symptoms and prolong life, but that an adjustment to the way of life compatible with the patient's temperament, personality, and surroundings is nothing more than sensible physiologic treatment. Amelioration of some of the burden of anxiety on an already taxed heart and circulatory system seems worth while in prolonging life—or at least may add to the joy of that span of life left to these individuals.

May I say in conclusion a word of warning? I am deeply in agreement with those who desire added psychiatric training for the medical student and the graduate physician. But let us remember that serious organic disease of the heart and blood-vessel system—or, for that matter, of any vital system—does occur independently of the patient's personality or life situation. Therefore, no lowering of standards of education of the doctor in the recognition of structural disease or its management must be allowed. Rather, integration of knowledge concerning both psychic and physical disturbances is the aim, without over-enthusiasm as to the importance of either.

In the final analysis it must always be the duty and the privilege of the patient's *personal* physician, be he specialist or general practitioner, to collect the threads of the patient's emotional and physical problems, evaluate their relative importance, and guide the person toward the best possible design for living.

PROBLEM DRINKING: A CHALLENGE TO PSYCHIATRY

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THERE are in the United States to-day an estimated[1] 750,000 acutely and 3,000,000 episodically ill people, many with a strong psychiatric component, who are treated as social pariahs—not as patients. These are the chronic and excessive problem drinkers. Neglected by the medical profession,[2] abused by society, they are the twentieth-century counterpart of the mentally ill patient of not too many decades ago. For want of recognition of their condition and needs, by physicians as much as by society, they overflow our jails and overwhelm our relief and welfare agencies.[3]

In the light of present medical knowledge, problem drinkers are an enigma and a source of concern to physicians. They are the bane of police, court, and welfare agencies. They are an economic dead weight on society. Yet—on the basis of economics alone—they are worth helping. They are salvageable. One group alone, Alcoholics Anonymous, many of whom had hit the bottom rung of the medical, social, and economic ladder, have at present an annual estimated earning capacity of $150,000,000.[4]

[1] See "Recent Trends in Alcoholism and in Alcohol Consumption," by E. M. Jellinek. *Quarterly Journal of Studies on Alcohol*, vol. 8, pp. 1–42, June, 1947.

[2] See *Institutional Facilities for the Treatment of Alcoholism*, by E. H. L. Corwin and E. V. Cunningham (Chicago: American Hospital Association, Research Report No. 7, 1944). See also "A Survey of Facilities for the Care and Treatment of Alcoholism in New York City," by the Committee on Public Health Relations of the New York Academy of Medicine *(Quarterly Journal of Studies on Alcohol*, vol. 7, pp. 405–38, December, 1946).

[3] See "The Alcoholic—A Public Responsibility," by J. Hirsh. *Social Forces*, vol. 25, pp. 426–28, May, 1947.

[4] Estimate given in a communication from one of the founders of Alcoholics Anonymous.

For no other complex medical problem—affecting the lives of 3,750,000 people directly and of 11,000,000 indirectly, to say nothing of its effects upon society in general—are the necessary study and medical care denied. Psychiatrists can profitably address themselves to these needs. To point up the areas in which they can do so is largely the purpose of this statement.

Research.—Despite abundant fundamental and clinical research on problem drinking, much of the research in this field is individual, segmental, and uncoördinated. There is much that is not known about the problem drinker—the etiology of his pathologic drinking, the psychopathology, diagnosis, treatment, and prevention. A review of the literature [1] suggests a number of lines of potentially productive inquiry:

1. The personality types of the problem drinker.
2. The personality of members and former members of Alcoholics Anonymous.
3. Emotional and personality changes in problem drinkers.
4. The psychosomatic make-up of the excessive social drinker; the etiology, conversion process, and psychobiological effects of those who become problem drinkers.
5. The existence and nature of psychological and psychobiological idiosyncracies that would make possible predictions concerning reactions to the use of alcohol.
6. The significance of precipitating factors in problem drinking.
7. Behavior characteristics common to problem drinkers and their symptomatology in relation to underlying psychosociological factors.
8. The psychology of motivation in problem drinking.
9. General psychologic factors in alcohol tolerance.
10. Specific individual factors in alcohol tolerance—*i.e.*, psychophysiological thresholds, including pre-experimental personality and developmental studies.

[1] See *Effects of Alcohol on the Individual*, by E. M. Jellinek. New Haven: Yale University Press, vol. 1, 1942; vol. 2, in process of publication.

11. The psychologic mechanisms of intoxication and habituation; the predominating emotional and motor symptomatology of different types.
12. Determination of an effective nosology on problem drinking.
13. The importance of problem drinking among acute and chronic cases of the mentally ill.
14. The rôle of acute alcoholic hallucinoses, delirium tremens, polyneuropathy among mentally ill patients.
15. The direct and indirect, permanent and temporary, effects of alcohol.
16. Nutritional encephalopathies associated with problem drinking.
17. The encephalography and brain metabolism of problem drinkers, especially in the so-called alcoholic psychoses.
18. Organic lesions in problem drinkers; findings in the central nervous systems of patients who die of "chronic alcoholism."

Whole areas of correlative research, equally profitable potentially, in which psychiatrists can play an important contributing rôle, exist in the fields of sociology, anthropology, history, and law. The possible and desirable areas of investigation in one of these fields is now being developed.[1]

Diagnosis and Treatment.—The greatest success reported to date in the treatment of problem drinking has been carried on by untrained lay therapists through the instrumentality of common interest and mutual therapy. Physicians and the public at large have turned continually to Alcoholics Anonymous for advice and leadership in the treatment of individual problem drinkers. The medical profession in general and psychiatry in particular is faced with the challenge to develop and apply scientific modalities in the diagnosis and treatment of problem drinkers. If left unchallenged, the treatment of this medical problem will continue largely in the hands of untrained laymen and will become more firmly entrenched there than it now is.

[1] See *Problem Drinking: A Challenge to Sociology*, by Joseph Hirsh. Manuscript in preparation.

The time is ripe and the need exists for:

1. A development of critical diagnostic procedures and a diagnostic nosology.
2. The establishment of standardization in therapeutic procedures.
3. A critical evaluation of the results of the Alcoholics Anonymous program, and the position that organized psychiatry should take with reference to it.
4. The development of in-patient, clinic, and extra-hospital (community-wide) rehabilitation programs.
5. Determination of the rôle of psychiatric and other social workers in rehabilitation and follow-up programs aimed at the reëstablishment of the problem drinker and the prevention of problem drinking.

Facilities for the Care of Problem Drinkers.—The two major studies undertaken under the ægis of the Research Council on Problems of Alcohol on the facilities available for the medical care of problem drinkers indicate the existence of gross inadequacies.[1] Aside from a few proprietory sanitaria, public and private hospitals do not as a rule accept problem drinkers as patients. Mental hospitals generally will not accept non-psychotic problem drinkers and at best care for only a limited number of the psychotic alcoholics. As a group, psychiatrists can make themselves felt and heard in having the doors not only of mental and special hospitals, but also of general hospitals opened to both groups of patients.

The thousands of requests from problem drinkers and their families for information about institutional facilities carry the following challenge to psychiatry:

1. To survey and evaluate existing mental-hospital facilities and the methods of treatment employed, with the view of establishing standards of therapy and a directory for professional and public use of acceptable institutions;

[1] See Corwin and Cunningham, *op. cit.*; also Committee on Public Health Relations of the New York Academy of Medicine, *op. cit.*

2. To coöperate with other professional groups in a similar survey and evaluation of existing general-hospital facilities and the methods of treatment employed, with the view of establishing standards of therapy and a directory for professional and public use of acceptable institutions;
3. To evaluate the rôle of psychiatrists, mental hospitals, and mental-hygiene clinics in the treatment of problem drinkers.

Legislation.—Beginning three or four years ago, at which time several states established official commissions on alcoholism, an increasing number of legislative measures have been introduced in the national and state legislatures directed toward focusing the medical sciences on problem drinking. Increasingly these legislative proposals have recognized problem drinking as a medical problem. They have ranged from the establishment of clinic facilities only, to the construction of special hospitals and farm or industrial colonies for problem drinkers. While well intentioned in their recognition of problem drinking as a medical problem, many of these legislative proposals are confused and contradictory. They are confused in the sense that they propose incomplete measures and inadequate facilities to meet this problem. No provisions are made for adequate research into causes and means of prevention, into the development of sound measures of differential diagnosis, treatment, and rehabilitation of problem drinkers. There is apparently no basic understanding of precisely the kinds of facility that are needed to meet the needs of various types of problem drinker—the episodic, the psychoneurotic, the senile and deteriorated types, for example. There is no adequate understanding of the standards necessary for these facilities, of the personnel required to man them, of their qualifications, and their duties. Many of the legislative proposals are contradictory as well in as much as they recognize problem drinking as a medical problem, but call for the establishment of medical facilities within the jurisdiction of the correctional rather than the medical agencies of government.

Unless guidance is forthcoming from the medical profession, it is possible that large amounts of public funds will

be allocated injudiciously and expended without proper consideration of the types of facility that are actually required.

Professional skills can, therefore, be profitably directed to:

1. Determination of the type or types of medical facility that should be provided for the care of problem drinkers in terms of (a) research diagnostic treatment centers; (b) general-hospital in-patient and out-patient service; (c) extension of mental-hospital facilities; (d) special alcoholic treatment centers; (e) medically administered farm colonies for salvageable chronic alcoholics.
2. The development of standards of operation, administration, and personnel, in each of the above mentioned facilities.
3. The establishment of criteria of therapy for various types of problems drinkers in the above mentioned facilities.

Urgent as is the need for medical facilities for problem drinkers, there is much that we do not know about them, as already indicated, which suggest the need of encouraging intensive research at this time instead of large scale *new* general-facility programs. Psychiatrists can help immeasurably in furthering those moves that are currently being made to establish centers that will provide in-patient service as well as clinic service, and that will integrate research, diagnosis, treatment, prevention, rehabilitation, and follow-up in such ways as to be models of medical practice as well as of administration.

An inherent function of such centers should be the teaching and training both of medical and of non-medical personnel in the care of problem drinkers. Such centers should be established in connection with leading medical schools and their affiliated hospitals in order that their personnel and facilities may be most advantageously utilized in a coördinated fashion.

Medico-Legal.—As a result of the present legislative confusion, and the emerging concept of "alcoholism" as a medical problem, it is mandatory that serious consideration be given to recodification of the law with reference to the handling and care of problem drinkers. As is indicated in an increasing number of new laws, problem drinking is becom-

ing accepted as a medical problem; therefore, the problem drinker should no longer be subject to the criminal code. Stimulation by the medical profession of an evaluation and recodification of the law with reference to problem drinking would affect a wide variety of present-day confusing and contradictory situations. The laws relating to traffic accidents and crimes against persons, to divorce as well as to vagrancy, the inconsistency in the Blue Cross hospital plan with reference to problem drinking as an illness, as well as vital statistics, would all be affected. Many of these problems have a direct bearing upon the professional practice of psychiatry, and psychiatrists, perhaps more than any other group within the medical fraternity, can best assist in rectifying the ironies and contradictions in the law. They can encourage the development of sound laws consistent with the medical acceptance of problem drinking as a disease or as a symptom complex.

Theirs can be a notable contribution to society in assisting in the development of model community laws pertaining to the medico-legal problems of problem drinking.

The suggestions outlined above are proposed not as a definitive program, but as representative of the areas in which knowledge is lacking and in which it is much needed.

COÖPERATION AND CONFLICT IN THE MENTAL DEVELOPMENT OF THE CHILD *

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BECAUSE physical conflict is wasteful and devastating, educators frequently assume that the process of facilitating the mental development of the child is more effective when conflicting forces are avoided. It is my purpose here to examine this assumption in several fields of experience and research.

Let us consider first the conflict between isolation and socialization in the development of children. In the nineteenth century it was commonly believed that the mental development of the child was facilitated by individual attention and that it was desirable for him to be instructed individually by his mother or his tutor. Now the trend has been reversed. Educators of small children talk much of socialization and have established play schools, nursery schools, and kindergartens, which commonly give greatest emphasis to the social adjustment of the child in working and playing coöperatively and constructively with his mates.

More recent nursery-school studies, however, raise grave doubts about exclusive emphasis upon either isolation or socialization. Observations of small children in nursery-school situations have shown common patterns of child behavior in which the child alternates between periods of coöperative social activity and periods of isolated individual activity. Preliminary results from some experimental efforts to provide these alternate periods of isolation and socialization indicate more rapid development of the child, particularly more rapid development of control and of emotional poise in social groups.

Studies of adolescents also show a preference on the part

* Lecture delivered in the University of Chicago Symposium on "Coöperation and Conflict," November 16, 1945.

of youth for alternating periods of being alone and being with others, of individual activity and of group activity. Students of Moreno and of Lewin both report that the criteria of emotional stability, social interaction, and personal effectiveness in meeting school tasks are all better met when the school environment provides an alternation between these conflicting conditions of isolation and socialization. In this case, it does not appear that the elimination of the conflict between group activity and individual activity facilitates the development of the child.

A second area of conflict frequently discussed in educational circles is that between directed positive adult leadership and the avoidance of adult control in educating children. This conflict was most explicitly recognized by Rousseau, and he resolved it in his philosophy by advocating the elimination of positive adult leadership and dependence upon the growth forces within the child for direction. Much of the controversy between the so-called progressives and the traditionalists in education has arisen over the conception of the place of adult leadership in education. The progressives have in some cases followed Rousseau's views and recommended the avoidance of positive adult controls. On the other hand, the essentialists strongly endorse positive adult direction.

Recent studies, particularly those of Kurt Lewin, formerly at the State University of Iowa, throw significant light on this controversy. These studies have been reported in various journals and monographs, as, for example, Lewin's *Experiments in Autocratic and Democratic Atmospheres*[1] and *Studies in Topological and Vector Psychology—Frustration and Aggression.*[2] In these studies three comparable groups of children were given the same instruction in three different types of social environment. One group was directed by forceful, positive adult controls, so-called autocratic leadership. A second group was given no definite adult direction. The leader was there to help when asked, but he made no effort to control the group. This was called *laissez-faire* leadership. The third group had a leader who acted as a member of the group, giving respect and consideration to the ideas of the children and expecting the same treatment from them. As difficulties

[1] *Social Frontier*, Vol. 4, pp. 316–19, July, 1938.

[2] Studies in Child Welfare, Vol. 18, No. 1. Iowa City: University of Iowa, 1941.

arose, he suggested methods of dealing with them, but he did not force ideas upon the children or strongly direct their actions. This was called democratic leadership.

Observation of the groups indicated that under autocratic leadership, the children's attitudes alternated between hostility and apathy. The *laissez-faire* group showed frustration and aggression. In terms both of lessened tensions and learning effectiveness, the democratic group was the most successful. It would appear that in this situation, too, the development of the child is facilitated, not by the elimination of positive leadership, but by the use of a form of leadership in which conflicting forces are balanced.

A third area of conflict in educational theory is that between success and failure in school. Practical school experience and psychological studies both have indicated negative, often devastating, effects of failure. Children have lost confidence, have ceased to be interested in school work, have even hated educational activities, and in many cases have developed patterns of antisocial behavior as reactions to school failure. As these results have become known, there has developed a movement to establish a policy of "no failures" in some school systems.

Before this policy is generally adopted, however, educators need to examine some of the recent research studies that throw light on the issue. Daniel A. Prescott reports some of this work in his volume, *Emotion and the Educative Process.*[1] These studies show clearly enough that success is a powerful motivating factor in the development of children. They also indicate that success gains its major significance only in relation to failure. Failure has a function in human life. It gives meaning to success as the avoidance or alternative to failure. It has a social function in helping a person who experiences failure to understand and appreciate the failure of others. Occasional school failures prepare the individual for meeting occasional failures in later life. Having learned that he can take failure, he does not regard it as a catastrophic experience.

The conclusions that might safely be drawn from recent studies in this field is that each child's learning requires a

[1] A report of the Committee on the Relation of Emotion to the Educative Process, American Council on Education. Washington, D. C.: American Council on Education, 1938.

balance of success and failure—much more success than failure, but some of both. Now, the typical situation in schools is that certain children have all successes and others have almost all failures. This condition is bad for both. It is not the elimination of these conflicting evaluations, success and failure, but their balance that is required for the effective development of the child.

A fourth area of conflict is that between learning that provides new syntheses, new perceptions, and new facts, and learning that provides reflection upon previous experiences. Hundreds of studies have shown that children in large numbers fail to comprehend the organized generalizations of textbooks. This has led to a strong movement to make the chief and well-nigh exclusive work of the school one of providing first-hand experiences and opportunities to deal with facts directly rather than with generalizations. Even the developmental study of Piaget was interpreted to support the practice of avoiding generalization, abstraction, and organization in childhood learning.

One of the chief challengers of this position, and the earliest to work out a consistent philosophic and psychologic view on the matter, was Mary Boole. In her monograph, *Preparation of the Child for Science,*[1] she developed the theory of generalization as "unconscious experience first, the principal made conscious later." In arithmetic, for example, the child is able to generalize abstract concepts of three-ness, four-ness, and so on and to recognize the meaning of the statement, "Six is five and one, and four and two, and three and three, and three two's, and two three's," by a great deal of direct experience with objects, in which he sees, by handling of the objects, that three apples and three pencils have three-ness in common, and that six objects can be grouped in each of the ways represented by the combinations indicated.

A great deal of this first-hand experience must be provided before efforts are made to generalize about the abstract relations involved. This same view was later expressed by Dr. Judson Herrick, the well-known neurologist, in these terms, "Things must be acted out before they are understood." The

[1] New York: Oxford University Press, 1904. pp. 68, 85–87.

results of the Eight-Year Study[1] also provide evidence to show that exclusive attention either to learning that provides new experiences or to learning that provides reflection upon previous experience is not nearly so effective in developing increased understanding and ability to deal with problems as is a pattern of learning in which opportunities for new experiences alternate with opportunities for reflection upon previous experience. In this field, too, it appears that mental development is facilitated, not by avoiding conflict, but by balancing the conflicting types of experience.

A fifth area of conflict is that between learning as adjustment to external demands and learning as development of individual potentialities. There have been conflicting schools of thought on this issue for centuries. The form it takes to-day is the either-or view of traditional or of progressive education. In terms of the traditionalist, the primary job of the learner is to adjust to external demands. In disciplinary terms, he must learn to live by the rules laid down. In content terms, he must master the content of textbooks. In skill terms, he must acquire the skills of reading and writing as they have been worked out and made a part of social convention. In attitude terms, he must acquire the views of the dominant group in society and respect the symbols that they hold high.

The progressives, on the other hand, are likely to take the reverse view. Potentialities for growth lie within the individual. The environment must not inhibit these growth potentialities. In terms of discipline, learning involves freeing the individual to follow his own bents. In terms of content, he should find out those facts and ideas that are of interest and use to him. In terms of skill, it is important only for him to become facile at things that capitalize on his interests and potentialities, and his attitudes should express his own views, his own purposes, hopes, and aspirations.

Interestingly enough, John Dewey, the philosopher of progressive education, has strongly criticized this either-or position in his book, *Experience and Education*.[2] He formulates

[1] See *Story of the Eight-Year Study, with Conclusions and Recommendations*, by W. M. Aikin *et al.* (Progressive Education Association, Committee on the Relation of School and College. *Adventure in American Education*, Vol. 1.) New York: Harper and Brothers, 1942.

[2] New York: The Macmillan Company, 1938.

a view that gives equal weight to external demands and to individual potentialities in education. His philosophic position is that the best learning experiences are those that change the individual because external conditions make some demands on him and that give opportunity for him to make some changes in external conditions. It is not the elimination of external demands or of individual desires, but their balance, that seems to Dewey philosophically sound.

In nine of the thirty schools that participated in the Eight-Year Study, there was opportunity to test Dewey's hypothesis. In these schools the experimental groups used learning experiences that were selected on the basis of their providing opportunities both for making demands on the learner and for giving him a chance to modify external conditions. In some of the schools, other groups had learning experiences that involved only adjustment to external demands. In the other schools, the control groups were largely free to follow their individual interests. The results indicated that, in terms of academic achievement, personal satisfaction, and social adjustment, the learning experiences that provided a balance of external and internal forces were best.

A sixth area of conflict relates to the conditions under which students arrive at what is for them creative generalizations. On the one hand, the view is held that creative generalizations develop from a consideration of opposing hypotheses, while, on the other, it is held that forced effort and inspiration are the primary conditions. A recent volume from the Princeton University Press, by the French mathematician, Jacques Hadamard, entitled, *The Psychology of Invention in the Mathematical Field,* reviews several investigations, based on introspection, of the process by which famous mathematicians have arrived at their creative formulations. He concludes that creative work in mathematics usually involves a conscious reflection on the problem with attempts to solve it, then a period of unconscious incubation, followed by a quick conscious perception of the solution, and then a longer, laborious check to see that the solution really works.

This view is not completely in harmony with the theory formulated by George Boole in his *An Investigation of the Laws of Thought,* or by Gratry in his *Logique,* or by Mary Boole, who applied George Boole's and Gratry's theory to

her work with education. In her monograph, *The Mathematical Psychology of Gratry and Boole,* she outlines the process of creative induction as one in which a problem is perceived, is analyzed, conflicting hypotheses are examined in terms of elements common to both, and then, with the results of this analysis in mind, concentration of attention on the problem is stopped. During the period in which conscious attention is not directed toward the problem, a kind of subconscious synthesis apparently takes place, because a later consideration of the problem is likely to provide an integrated solution.

This alternation of analysis and synthesis and of conscious and subconscious action is also in harmony with the postulates of symbolic logic, which involve alternation between zero and infinity. Its effectiveness with children in mathematics and science as a general inductive procedure was tested by Mary Boole and has been tried with children in various classes in this country, as in the early work of Speer in arithmetic and of Brownell in science. Although this examination of conflicting hypotheses is not included in Hadamard's description, his cases clearly show such a step—for example, in his explanation of Poincaré's discovery of the theory of Fuchsian groups and Fuchsian functions.

The application of this theory to all educational fields in which it is hoped that students will arrive at what is for them creative generalizations, is a promising next step in school procedure. In the social studies, in place of developing a single set of hypotheses to explain social behavior and social forces, the Boole procedure would involve examining at least two extreme hypotheses to determine what elements are common and what are the extreme implications of each. Having done this, conscious attention would not be directed at the problem for a period of time; and then, on reconsideration, the students would be expected to perceive generalizations and possible solutions to problems that would not have been clearly apprehended by the usual direct procedure of analysis. Even in the field of the fine arts, this theory has interesting applications that need to be explored by experiment.

In this field of teaching children to make inductive generalizations, the conflict between analysis and syntheses, between concentration and conscious attention and enforced inspira-

tion, is not well-resolved by taking one or the other of these conflicting pairs. Rather, it appears likely that mental development is facilitated by providing a balance between both of the opposing sets of elements.

We have examined six areas commonly involved in the mental development of children. It has frequently been maintained that mental development is facilitated by emphasizing only coöperation and eliminating conflicts in the child's educational environment. If our analysis of these six areas is valid and if these areas are representative of all the areas of mental development, we may safely conclude that mental development is not facilitated by the elimination of conflict, but that conflict has a real and significant function in promoting the mental development of the child. The principle is neither to avoid conflict nor to include conflicts as unsoluble, incompatible conditions. Rather, conflicting forces are to be chosen and utilized so as to provide a balance. In order that effective integration may take place in the child's mental development, conflicting drives, impulses, external demands, and ideas must be balanced, not eliminated.

NOTES ON PERSONALITY DEVELOPMENT

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A THOUGHTFUL young friend of mine had returned from a series of very dangerous missions in the war. He had always had a keen interest in life's problems, but suffering and fear and constant closeness of death had deepened his interest and increased his insight. In each of our conversations he would come back to the question, "How can I grow toward the kind of person I long so much to be? By what process can I become a better instrument for the service I wish so much to render in life?"

He had a way of putting these questions directly to me and he refused to be satisfied with vague, general answers. The need was too urgent to be met with empty phrases. He would listen courteously, but the expression on his face and his further questions showed that I was still not giving him the help he wanted. Our conversations led to much thought, and together we developed the following ideas. Perhaps others may find these suggestions helpful.

The best personal development results from a continuous cycle of three types of activity: (1) stimulation, (2) assimilation, (3) expression. Personality development is best when these three activities are of the right kind, amount, and proportion.

Stimulation is largely a process of receiving. Personality does not grow in a vacuum. In the very act of living one is constantly being bombarded with stimuli that come in through the organs of sense from the outside world. These impressions continuously change the personality—its impulses, habits, sentiments, desires, ideals. In an ordinary day of activity, the average person receives a great deal through each of his senses. The mechanical devices of the modern city, the endless radio, the newspaper, the constant social intercourse of modern life—these and countless other stimula-

tions flood in upon the mind of modern man. He does not lack material to receive—in truth he cannot escape reception.

Although stimulation is necessary to growth, not all stimulation is good. The personality is changed by what it receives, but how it is changed depends upon the quality of the stimulation. Ugly, confused, meaningless, or shallow stimulation may reorganize the personality, but not in terms of truth, beauty, and goodness.

The individual who understands himself and life to a reasonable degree can learn to seek those experiences that enrich and make whole his personality. It is true, life to-day offers a great variety of stimulation; and although much of it is bad, does harm rather than good to the personality, for the person who will seek there is an abundance of good stimulation available. The mention of a few avenues of receiving will suffice for illustration.

First of all, there is nature—the sky by day and by night; plant and animal birth, life, and death; the sea; the rain; a meadow or wood at dawn or twilight or midday; a soft-flowing river; a brook or waterfall in a deep shade. The list is endless and no one can put a price on these things; even the poorest of us, caught in the extended web of the modern city, cannot be deprived of nature if we have the senses and the will to receive her.

Then, there is reading—the greatest thoughts of the greatest men made easily available to us. One calls to mind Keats's ecstasy when contemplating the joy and profit of reading:

> "I had an idea that a Man might pass a very pleasant life in this manner—let him on a certain day read a certain page of full Poesy or distilled Prose, and let him wander with it, and muse upon it and reflect upon it, and bring home to it, and prophesy upon it, and dream upon it, until it becomes stale—but when will it do so? Never. When Man has arrived at a certain ripeness in intellect, any one grand and spiritual passage serves him as a starting-post towards all the 'two-and-thirty Palaces.' How happy is such a voyage of conception, what delicious, diligent indolence!"[1]

There is, of course, an appalling amount of reading matter that is neither true, nor beautiful, nor good. At best, the stimulation from such reading is thin and meaningless; at worst, it is a literal mental poison—a menace to mental health

[1] Letter to John Hamilton Reynolds, February 19, 1818.

and well-being. But no one is compelled to read poor or bad literature. He does not have to read the horrors and filth that comprise the bulk of many newspapers, for there are newspapers that give space to murder, rape, robbery, and so forth, only in proportion to the frequency of their occurrence in modern life. Why must or should one read an account of all the worst things that happen each day in the world, or for that matter in a large city?

The modern library offers, free to all who can read, the opportunity to receive the thoughts and feelings of all the good and wise men of all nations and all ages. Noble and beautiful ideas received into the personality will help it to grow toward the fulfillment of its potentialities.

Also, there is music and art. The radio and phonograph have brought within the reach of every interested person the very best in music performed by the greatest artists. To-night in my own living room I have listened on the phonograph to the Ninth Symphony of Beethoven. The records cost only a few dollars and can be played numerous times. Thus, the beauty of Beethoven's heart and mind is mine to receive.

The standard of radio programs is in general low. One can listen hour on hour to soap opera, murder mystery, quiz show, dull comedy, tawdry music, or propaganda under the guise of comments on the news. But, again, one does not have to listen to the worst programs. Almost any time day or night one can get great music; music that helps rather than harms the personality, somewhere on the dial. At many times during the week, the finest music can be had from many stations.

The best in art is not so available to the average citizen. Yet as skill in reproduction has improved and good reproductions have become inexpensive, art has become increasingly available to all. Nearly all large cities have good museums open to the public; many smaller cities could bring art to their citizens.

The mention of one other source of stimulation will suffice —namely, the spoken word in all its myriad forms. Conversation with thoughtful friends, lectures, sermons, forums, drama —these are all delightful and profitable. True, much conversation may be gossip or wisecracking, many lectures and forums pointless and dull, many sermons thin and repetitious, and many dramas a melodramatic portrayal of the sordid or

the commonplace, but they are not always or necessarily of such low standard. The seeker after constructive stimulation will find conversation that is rich in thought and feeling, lectures that are clear and informed, sermons and worship full of inspiration, and drama that gives fuller meaning to life.

Stimulation may be of poor quality and may be insufficient in amount, but there is also great danger in too much receiving. Even good stimulation—as is the case with good food—may be taken in too great amount or at too frequent intervals. We are often reminded of the truth expressed by Pope:

> "Vice is a monster of so frightful mien,
> As to be hated needs but to be seen;
> Yet seen too oft, familiar with her face,
> We first endure, then pity, then embrace."

Yet we may forget a related point of as great or greater importance—namely, that stimulation too frequently given or inappropriate to need or to maturity level rapidly loses its potency. It is a fundamental principle that the senses and probably the higher mental processes cease to be moved by a too-oft-repeated stimulus. The human mind craves variety of stimulation and is best satisfied by a rhythm of now more and now less.

The optimum stimulation probably varies with the temperament and previous experience of individuals as well as at different maturity levels of the same individual. Although surety on this point must await the discovery of additional facts, it seems to be a good guess that the modern individual of all ages is dangerously jaded by overstimulation. A multitude of inventions, from the printing press onward, have increased the flood until there is almost no escape in the country or in the city, at home or abroad, by day or by night. The spoken word that formerly had something almost magical about it, the written word, and even the picture, so elementally potent for the human mind—all tend to lose their edge as sensitivity decreases, so that those who wish to attract and hold the attention of modern man are driven to more and more bizarre and gross stimulations until we have the singing commercial and the horror of the morning paper's front page, the extremes of many moving pictures and books, and so on. By the process of negative adaptation (becoming used to) the

human mind becomes less sensitive as the amount of stimulation increases, and by necessity those who seek to reach it must scream louder. Clearly this process is circular, and hence we can hardly imagine what the end will be.

One other aspect of this problem merits consideration. The attempt to overcome the jaded condition of the senses and higher perceptions of modern man eventually takes the means of appealing to and disturbing the deepest unconscious processes of the mind. The result of this irresponsible stimulation of primitive, impulsive tendencies may be a disproportionate emotional upheaval and the release of energies and impulses not easily within the control of the individual personality organization, or even the social organization. Many thoughtful students of human nature fear the consequences of the orgy of violent stimulation given the general public by the detailed reporting of the incomparable violence of the last ten years, not to mention the experience of those individuals who were forced to experience the horror directly.

The best forces within man have struggled long to put some of Pandora's evils back in that fateful box. The radio program that strives for the ultimate in horror, the newspaper that covers its front pages with pictures of the distorted bodies of hanged Nazi leaders, or charred bodies in rows from a fire tragedy, or the grief-stricken face of a bereaved mother; the book that seeks the utmost in vulgarity, brutality, and debauchery; the movie that parades in lifelike pictures every evil that has plagued man—all these agencies that go to such length for attention and consequent profits are playing with exceedingly dangerous forces; to use another figure, they are doing their best to pry open Pandora's box of curses. Whether or not we have already released the forces that will destroy our civilization, no one can say.

This much can be said with confidence: Any one who wishes to achieve the best in personality development not only will find a way to improve the quality of the stimuli he receives, but will strive to limit to a reasonable degree the amount of stimulation to which he is subjected. The implications of this principle for all aspects of education can hardly be overestimated.

Receiving is only one phase of the growth process. That which is taken in must be assimilated—*i.e.*, made a part of the

personality. The process by which raw experience is assimilated into the personality structure is not well understood. We know that all action of this type is slow and goes on in terms of the nature of the organism and its level of maturity.

In the early years of development, all three of the phases of the growth cycle are largely unconscious and proceed naturally if the child has some freedom to experience and to react to experience. As maturation continues, the two end phases—receiving and acting—come more under conscious control and are relatively easily influenced by education; in fact, the person becomes self-conscious about them, learning to control and alter them to serve his purposes. But the inner process of assimilation remains largely unconscious, haphazard, and undirected. The result is that, however rich the stimulation may be and however ardently the person may strive to act, his growth is poor because experience is not "digested" and hence little or no transformation in personality structure takes place.

It is this failure to assimilate the raw material of growth that leaves most personalities infantile when they should be mature. Psychologically infantile persons have trouble with all of life's relations—marriage, work, play, social relations, and so on. In truth, nearly all of the sore ills of modern man are caused by the fact that men and women deal with situations demanding the wisdom of maturity with the narrow perspective and poor skill characteristic of the infantile personality.

Effective assimilation is particularly difficult for people of this age. Human life is almost an orgy of receiving and acting. Our society is overstimulated and hyperactive. Modern man is, in the main, out of sympathy with both the conditions and the processes basic to assimilation, and yet assimilation is absolutely essential to the growth of human personality.

The mind seems to be naturally active. The task of assimilation is to see that the action is not completely taken up with sense and motor activity. There must be some essentially mental action in which sensing and motor responses are at a minimum. Mere quiet promotes the assimilative process. Emerson was fond of pointing out that we should listen more to the "voice" within. Many wise men before and since have

made the same emphasis. For example, Plato in his *Phaedo* says:

> "And were we not saying long ago that the soul when using the body as an instrument of perception, that is to say, when using the sense of sight or hearing or some other sense (for the meaning of perceiving through the body is perceiving through the senses)—were we not saying that the soul, too, is then dragged by the body into the region of the changeable, and wanders and is confused; the world spins around her, and she is like a drunkard, when she touches change?
>
> "Very true.
>
> "But when returning into herself she reflects, then she passes into the other world, the region of purity, and eternity, and immortality, and unchangeableness, which are her kindred, and with them she ever lives, when she is by herself and is not let or hindered; then she ceases from her erring ways, and being in communion with the unchanging is unchanging. And this state of the soul is called wisdom."

Although solitude is in bad odor in this age, it has often been praised by wise men. It is often good, after a period of stimulation or action, to withdraw into complete quiet, for then it seems that assimilation goes forward when the mind is apparently unoccupied. There is some evidence that reorganization goes forward even during sleep. If this is true, sleep is a positive assistance to the rhythmic cycle of mental growth—at least, in this way the mind has some respite from constant stimulation and action.

Some find their minds most effective after sleep, but many others are confused. Still others report the greatest clarity and originality—the greatest evidence of growth—after a period of "idling" or relaxation. There are wide individual differences apparent in this regard which are due doubtless both to constitution and to previous experience, but each person probably could find the type of situation that most effectively stimulates assimilation in him.

Probably, however, the best assimilation results from active meditation—an art little cultivated in modern life. To hold the attention to a problem for an extended period produces more and clearer insights. The manipulation of concepts and images creates new combinations and discovers new relationships. As a result of such mental action, experience becomes related to former understandings and learnings and thus personality is enriched. During and after such periods of meditation, thoughts of surprising originality often present themselves to consciousness.

One of the uses of genuine prayer and worship is that it helps this assimilative process. A weakness of much of spiritual exercise is that it is too sensory and motor, and hence fails to assist in this inner reorganization. It is not that the physical action is not good for the personality, but that there is a dearth of situations that promote "inner" experience and spiritual exercise, which in their very nature are suited to this process.

The importance of the assimilative aspect of growth and the likelihood of its neglect may account for the warning that nearly all religions give against the senses. Many thinkers, influenced by these warnings, have condemned sensory experience almost *in toto*. Thus man often has been led into a negative attitude toward the senses which is as fatal to balanced growth as is over-enthusiasm for sense or motor experience.

The extreme asceticism or abstraction of the Indian monk seems foolish to the Western man. But to the Indian seeker after light and peace, the flood of sense impressions and the continuous reaction to them disturb the soul and make insights into reality impossible. Both are right and both are wrong. The full development of human personality comes from a balanced, properly proportioned cycle of receiving, assimilating, and acting.

The cycle that brings growth is complete only when the assimilated experience is expressed in action. The richest receiving, followed by the fullest assimilation, leaves the personality basically unchanged until the process is completed in behavior meaningful to the individual. William James has suggested that it is damaging to the personality to listen to noble music or to a stirring sermon and fail to act in response to the inner stirrings thus stimulated.

Although as long ago as Aristotle it was recognized that we learn, in the final analysis, by doing, still formal education has almost always attempted to create learning (change of response) by stimulation together with perhaps a little unguided opportunity for assimilation and almost no related and hence meaningful activity. This fact accounts for the small influence of most formal teaching on character development as compared with the effect of varied, direct experience. Direct experience nearly always offers opportunity for, and frequently demands, reaction or activity.

The best personality growth requires action in response to stimulation and in terms of assimilation. A beautiful view, a thoughtful article, an inspiring sermon, each should find its way into new behavior. To know or to feel and not to act is to enter upon the way to a stagnant personality. To be stirred by a description of the starving and cold children of the world and then to return home to warmth, comfort, and indifference is to indulge the dangerous luxury of an incomplete behavior cycle that eventually leads to insensitivity—a condition destructive of growth at its very roots.

Perhaps the most crucial part of the growth cycle is the nature of, or general effect of the whole reaction pattern—"satisfyingness," as Thorndike termed this process. The transforming effect of a deeply satisfying response is strangely great. It may be argued that Thorndike never completely demonstrated how his law of effect worked, but no one who knows the facts can doubt that it does work with telling potency.

Professor Hocking has expressed this point in different terms, but very clearly:

> "But I am here pointing out simply a law of human nature as a fact to be reckoned with: *it is the mental after-image which determines whether a given sequence shall be confirmed or weakened, and how it shall be modified.* If the after-image is positive, any discomfort is prevented from eating into the allurement of the stimulus; if it is negative, any delight is prevented from enhancing it.
>
> "The nature of this after-image should be evident from our previous discussion. It is the reaction of the *whole will* upon the partial impulse, when the full meaning of that impulse is perceived in the light of its results. It is not necessarily a moral reaction; remorse, shame, æsthetic revolt, etc., are its clarified varieties. Its significance may simply be, 'This is, or is not, what *on the whole* I want'; 'I was a fool'; 'I hit it right.' In the unfinished condition of our instincts (and the slightness of our experience) every course of action is launched more or less hypothetically. It is my theory, as I make my decision, that this is what I want to do; yet I am aware that there is some doubt about it, and that I shall not be sure until the returns are all in. The mental after-image is the answer to the question involved in this tentative state of mind."[1]

I have discussed the processes of personality growth (stimulation, assimilation, expression) separately, but in healthy development they are so interrelated as to be in reality one

[1] *Human Nature and Its Remaking,* by William Ernest Hocking. New York: Yale University Press, 1929. pp. 186–87.

process. By the very nature of the human mind, stimulation is accompanied by assimilation and action. In fact, much of this process may be automatic and unconscious. It is well to remember, also, that this cycle may be continuous—that is, a reaction often becomes a stimulation which in time produces other reactions, and so on. Although this continuous process may be such as to produce desirable growth, its nature is most evident where the result is negative or damaging. For example, a fear or resentment reaction in turn becomes a constant inner stimulation that produces many harmful physical and mental changes. In some cases these reaction processes (*e.g.*, general fear or anxiety, as analyzed by K. Horney in her *The Neurotic Personality of Our Time*) may become chronic and express what Adler was fond of calling the "style of life"; in other words, the characteristic way of dealing with problems.

Good education, whether formal or informal, self-directed or externally provided, should guide this cycle and should make sure that the quality and proportion of each phase of the process is optimum for the particular person at his particular stage of development.

At one time the best growth may require wide, varied stimulation; at another, much meditation or other types of mental digestion; at yet another, activity may be the phase of emphasis. The kind of situation most conducive to either aspect of the process differs for different stages of development. A single experience coming at the right time with just the proper proportion of stimulation, assimilation, and action often produces a profound and even decisive effect upon an individual's life. Many people clearly remember some of these key experiences in their lives, and correctly consider them as turning points in growth. Skill in education is largely a matter of setting the stage for these crucial experiences.

Such are some of the things my thoughtful young friend and I concluded about the nature of personality development. We are fully aware that although man may be moving toward the light in respect to the art of hygienic education, he is still much, much closer to the darkness than to the light. But we take courage from the thought expressed by one wise man: "It is not important where a man is; the important thing is in which direction is he traveling."

A STATE PROGRAM OF MENTAL HEALTH *

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THE passage of the National Mental Health Act has stimulated the states to examine their mental-health programs. Such an analysis, reorientation, and addition must be carried out with a clear awareness of what the state is legally enjoined to perform and in conformity with present-day trends.

The war has accelerated professional and public interest in psychiatry and has hastened its evolution. I think it accurate to state that the practice of psychiatry is developing in the direction of psychiatry in the community rather than in institutions. Specialists in this field are tending to establish private practices. Small private institutions for the mentally ill are flourishing and have long waiting lists. There is real interest in the development of psychiatric wards in general hospitals, and considerable thought is being given to the provision of special well-staffed institutions—which for want of a better name can be called receiving hospitals—wherein extremely active therapy is practiced.

Then, too, not only general practitioners, but the members of other specialties are becoming more and more aware of the very great importance of what has been called psychosomatic medicine. The trend toward voluntary-admission hospitals and intensive treatment has been greatly accelerated by electro-shock and insulin therapy and by pre-frontal lobotomy. It has been found that the active and proper use of rather intensive methods of rehabilitation, such as well-planned occupational and recreational therapy, add their significant bit to the more specific items mentioned above. It has been found, too, that the proper use of psychiatric social work and of family-placement methods, taken in conjunction with the factors just mentioned, have so reduced the need for prolonged hospitalization that psychiatry is

* Presented at the Minnesota Welfare Conference in Minneapolis, May 5, 1947.

well on the way to being just as much a part of a medical community as is surgery. In time the result will be evident in a rapidly increasing bed occupancy in state hospitals by arteriosclerotics, seniles, and those who have been presented for treatment at too late a date for our present therapies to be very effective. As more and more students complete their training in our specialty and its adjunct professions and techniques, this trend that I have been discussing is sure to be accelerated.

Nevertheless, the problem is vast and beyond private practice or private enterprise, and it is clear that state planners must supplement, for a long time to come, the facilities and services of private endeavor. Any state plan will need to include in its over-all program these items: (1) laws, (2) location, (3) buildings, (4) service, (5) training, (6) all-purpose mental-health clinics, (7) prevention and public education, and, finally and of great importance, (8) research. We can, I think, agree that all this planning must be based on the premise that we are dealing with sick people, most of whom, if properly treated, can be returned to the community in a relatively short time. The whole scheme must be within the framework of the public-health concept, which is to emphasize prevention and, where prevention has been inoperative or has failed, early therapy.

1. Laws.—My comment on commitment laws is brief, but the subject is of much importance. Great liberality—in fact, the same kind of liberality that now exists in general hospitals—must be practiced in terms of admission procedures in state institutions. One reason why patients arrive at state hospitals much too late is that the family, and sometimes the family physician, are reluctant to go through with the archiac commitment procedures now current in most of our states—procedures that usually result in a short jail sentence while hospitalization is pending. Certainly, revision of outmoded laws is of prime importance in any state planning; and, parenthetically, this provision should include specific legislative mandates to provide for the carrying out of every part of the program decided upon. Health laws should be medically oriented.

2. Location.—Great care should go into selecting the location of a hospital. It is poor planning to place a mental

hospital in the country. The place for such a facility is as close as is practicable to a community that offers varied and extensive medical service. In such a setting help can be obtained from all the other specialties, and the patients will have the great benefit of being in a milieu of good medicine. It is wise also to remember that, with modern therapies, large agricultural and other hospital industrial programs are becoming less and less satisfactory. Patients who are well enough to work in such enterprises now recover sufficiently to go home within a month or two.

In the past, state hospitals have been built a long way from medical centers of any size—in fact, often far from a community population of respectable size. Usually both the pay scale and the living accommodations are not satisfactory and not competitive with life in the community. The result has been the development of a small core of patient and often skillful individuals who, because they must, have developed a somewhat ingrown society of their own. In this society there is a constant and too rapid turnover of individuals who come to the hospital for a thousand and one reasons—varying all the way from a desire to save money to pay for a medical course, or to take postgraduate work, to the understandable, but less laudable, need of the alcoholic who sometimes works on the wards of state hospitals to get over one bout and acquire enough funds to go on another. Unhappily, the public does not yet quite realize the eternal hopefulness of the proper treatment of the mentally ill, and still thinks the job is custodial, hopeless, and non-gratifying. The result of this combination of legislative indifference, public apathy, and sociological determinants has been a lack of proper service and particularly a lack of adequate training of all those who must work with our patients.

3. Buildings.—It is not my purpose to use much of our time for a discussion of buildings. It is sufficient to say that construction must be planned around the specific purposes for which the facility is to be used. The medical-surgical departments should be planned as they would be in any good general hospital; the areas for receiving new cases will need ample space and provision of the facilities necessary for individualizing each patient. Details of construction must take into consideration the comfort of patient

and employee alike. Some of the buildings throughout the country are modern in many respects, yet are extremely noisy, poorly lighted, and ill ventilated. There should be careful study of noise control, lighting, ventilation, and heating. I have added the word, "heating," here, because of some of the newer methods that are being tried out and because so many hospital wards are unbearably hot when there is a change in the weather, owing to lack of flexibility in heat control.

Finally, a word about color. Too many fine buildings are rehabilitated or constructed fairly satisfactorily, and then the whole therapeutic effect is ruined by drab, dull wall and corridor colors.

One is tempted to go on and on discussing in detail this question of hospital construction. I suspect that one reason for this is that we can talk with more certainty about bricks and mortar than we can about psychiatric causation and treatment. And so it is, too, with the usual state legislature. Legislators are sometimes understanding in the matter of providing capital outlay for new structures, but it is another matter when one attempts the difficult task of interpreting to them the need for adequate service in the buildings so enthusiastically erected.

4. Service.—Any state program worthy of the name must include personnel standards in terms of quantity reasonably close to those set by the American Psychiatric Association in 1946. In quality, we require individuals trained in the various disciplines of the adjunct therapies and qualified skills. Skilled nursing and ward service are the core of any good service program. For an adequate social-service program, there must be psychiatric social workers. For a program of occupational therapy and recreational therapy, there must be specialists in those fields. To understand properly the total personality of the patient, we need qualified psychologists. And to direct and give treatment, a therapeutic program demands psychiatrists who have had specific training in that specialty, either in special clinics or under the guidance of skilled psychiatrists who are good teachers.

Psychiatrists are not made by assigning a physician to a hospital ward or department and then assuming that he will learn by himself the skill of the specialist. Every hospital

of any size should have, as a full-time staff member, a specialist in internal medicine who has the primary responsibility of medical care and treatment. If it were possible to finance adequate staffs, and if it were now possible to employ a sufficient number of fully trained people, it would make all our lives less complex.

5. Training.—A live organization, even when it is fully developed, has a training program of its own or is affiliated with other training organizations. With the great lack of technical and professional help that is so obvious throughout America, the development of and participation in training programs is now essential. Therefore, a state mental-health program must include in-service training of personnel, collaboration with universities and other educational centers in an effort to improve and increase training facilities, and the best possible personnel practices within the economy of the state directed toward retaining desirable personnel. It has been said that government is the greatest training organization in the world, because as soon as an individual gets to know anything about the job, the working conditions do not make it possible for him to stay, and he goes into private industry or private endeavor. Certainly I agree with the part of the statement that concerns itself with separation from service, but I am not convinced that state governments do an outstanding job in training personnel.

6. Early Treatment.—State mental-health programs have been notorious in their lack of attention to the provision of facilities for early treatment of the mentally ill. Even in states where the hospital program is reasonably satisfactory, there is a practical dearth of facilities, either public or private, in this area. Great attention must be given to the establishment of all-purpose mental-health clinics dealing both with children and with adults. Such clinic facilities will in time not only reduce the load of hospital cases, but will add greatly to the reduction of maladjustment, alcoholism, broken homes, and delinquency.

These facilities can and must coöperate with schools, churches, courts, private practitioners, and family members in a program for developing individual potentialities to the highest possible level of adjustment, maturity, and constructive living. Such enterprises will unquestionably reduce sub-

stantially the very considerable numbers of our population who are unsocial or who, as an expression of their emotional disturbance, have become chronic invalids—not psychotic, but nevertheless unhappy, unfulfilled, and a burden to their families and to those with whom they work. The possibilities of properly staffed out-patient services, both resident and traveling, are indeed great.

There is another phase of planning for early treatment which must not be neglected, and that is the provision of well-staffed facilities either in state hospitals, if they be in or close to urban centers, or special facilities for intensive therapy of those patients whose illness requires hospitalization, but whose condition has not become so chronic as to require long-term care. At the beginning of this paper, I referred to the importance of bringing psychiatry into the medical stream of activity, close to the people and easy of access.

7. Prevention and Public Education.—The chief means to a positive program of prevention on the state level is a composite of several points of attack. A state should do everything in its power to support and encourage the proper teaching of undergraduate and postgraduate psychiatry in its medical schools. I make this point here because, when all graduates in medicine have a proper understanding of the psychiatric discipline, a very great step will have been taken toward the prevention of mental ill health.

For too many years psychiatry has been interpreted to the medical student from the back wards of mental hospitals; it is as if all instruction in medicine were confined to the pathological laboratory and the medical museum. Consequently, there is a lack of acute awareness on the part of the medical profession of the very early signs and symptoms of maladjustment, psychoneurosis, and psychosomatic diseases. Nor is the medical importance of the emotional development of the patient sufficiently clear.

Next in importance is the need to provide the clergy, educators, social workers, and the legal profession sufficient knowledge about human behavior to enable them to recognize the need for special care when it exists. We physicians are prone to forget that our patients are very often being treated well or ill by several other disciplines before they reach us.

All too frequently when we see the patient, the disturbance has progressed far and mishandling of the patient has served to make matters worse.

The foundation of good personality and good health is the family, and I am greatly impressed with the urgent need for instructing young people before they leave high school in the basic factors of family living and family adjustment. It is better to prevent family maladjustment than to deal in the clinics with its results.

I am sure that some of you are questioning my use of the words, "good health." But I should like to remind you that the chief reason why people refuse to go to physicians early in the onset of any illness is fear and insecurity, not basically because of the illness, but because of unresolved fears and insecurities that are the result of unfortunate emotional experiences in childhood.

In state planning for prevention, general information should not be neglected. Informing the public in layman's language about mental illness will serve to reduce fear and prejudice and will eventually result in an acceptance of the program similar to that now tendered to child-health, tuberculosis, and infantile-paralysis control. An information service will need to use the press, the radio, and the motion picture. All vehicles must be used.

8. Research.—It is not necessary, I am sure, to spend your time in the expounding of the importance of research into mental illness. Much too little has been done. Since most states have made it their legal responsibility to care for the mentally ill, it would seem to me only good business for the states to set aside an irreducible minimum of one-half of 1 per cent of their annual budget for this purpose. It is good planning, of course, to include a psychiatric institute or some similar enterprise as a state-operated facility, but it is very important, in my opinion, to coöperate with other agencies in the state by the provision of money for projects that have merit in this field.

In closing, I should like to underline the importance of interdepartmental coöperation in any state mental-health program. Unless considerable care is exercised, one finds unnecessary duplication of effort and sometimes actual contradiction of purpose. There must be close contacts and

coöperative planning with departments of health, welfare, corrections, and social administration. I should like to emphasize the importance of coöperating with the Public Health Service of the Federal Security Agency. The new National Mental Health Act and the Hospital Construction Act are tremendous potential aids in the solution of this problem. Every effort should be made by the states to take advantage of federal benefits and they should coöperate with this national enterprise. It is equally important to work closely with private agencies in the same and allied fields of endeavor. There is too often a tendency for public and private organizations to work along parallel lines, but not together. This is unfortunate and frequently a very considerable waste of effort.

To summarize, a state mental-health program requires consideration and coördination of the following:

1. Hospital admission laws consistent with good medical practice.
2. A building program that will provide satisfactory location, facilities, and sufficient beds to guarantee to the public the best in all the specialties in the medical and auxiliary disciplines.
3. The best possible hospital service, provided by a staff adequate in quality and quantity.
4. A coöperative training program involving not only the professional and technical personnel, but also the ward staff.
5. Provision both of resident and of traveling out-patient all-purpose clinics, staffed to provide not only consultation and diagnosis, but early treatment.
6. A special prevention and education program to interpret psychiatry to the public and to provide essential information to all those who are working with human beings.
7. A state research program that will not only involve the state department itself, but that will coöperate financially with any competent research individual or organization.
8. Coöperative planning and action with other state departments, the federal government, and private agencies.

OBSERVATIONS ON LEFT-HANDEDNESS

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THE occupational therapist, while using various activities as treatment measures to stimulate interest anew or to restore function, has a unique opportunity to observe hands in action. Thus the therapist becomes familiar with the various degrees of right- and left-handedness. Even if the favored hand were not indicated in the prescription, the therapist would be immediately aware of left-handedness and plan to adapt, as far as possible, all activities to meet this need.

Some of these adaptations of craft technique to left-handedness are as simple as starting the basket bottom with the weaving traveling from right to left instead of left to right, but, unless this is done, the left-handed individual has much difficulty performing even the simplest weaves. There are, however, activities that interest the individual which cannot be successfully adapted to this established performance pattern.

Left-handedness has long been the subject of careful study by the medical profession. If unlimited space were available, it would be of interest to present briefly the finding of these authorities. Our aim here, however, is to offer certain other observations that may be of value.

The therapist who is familiar with the techniques of a large number of handicrafts as performed both by right- and by left-handed persons will observe the following:

1. Some crafts and activities require continuous and almost equal skill in both hands.

2. Some require continuous use of both hands, but place the skilled part of the operation or technique in the dominant hand.

3. Other activities place the less skillful part of the technique in the dominant hand and require the more skillful performance of the other hand. Such activities also require continuous use of both hands.

4. There are activities that appear to require only the use of the dominant hand, supported infrequently by the other hand.

5. Finally, there are a number of activities that can be performed only with the right hand, and others that can be performed only with the left hand.

These observations lead to the belief that within certain limitations the development of an individual pattern of dominant-handedness may, and in some instances must, respond to environment and tradition.

New hand-skill patterns are more easily developed if these do not have to replace similar established patterns that are considered faulty or undesirable. It is always best to form only desirable performance patterns. But should it seem wise to change a pattern that has been formed, this would best be undertaken before the pattern to be replaced becomes too well established, though even then a change may be considered under favorable circumstances. By favorable circumstances is meant recognition by the individual of the need to change the pattern of handedness and a sincere desire to do so.

It is most important that the need to change a trend, pattern, or habit of handedness be recognized at the earliest possible moment, and that the replacing of this with the more desirable habit be undertaken at once, before it becomes a fixed pattern of action.

The replacement training involves primarily learning the movements of the various activities or techniques for the first time with the hand that it is desired to develop.

If the individual is already familiar with and has performed the activities with one hand, the sequence of motions is already known to him. This may be considered some help, but it must also be recognized that he may for some time have to strive to overcome the impulse to do it with the hand formerly used. This impulse may be present at first even if the hand that is being replaced is temporarily or permanently incapacitated or has been lost through amputation.

Any one who is aiding an individual in this replacement training must be very patient. The insight upon which such patience can be built can best be gained by trying quite seriously to do things with the left hand for which one has always

used the right hand. The method of assisting in such replacement training varies with the individual. It must also be adapted to the age group to which the individual belongs. Small children may react best when no assistance is apparent, and when it is arranged so that they may discover that it is fun to do things with the desired hand. Older children must be tactfully led to see the need for, and to desire to make, the change. Older persons may recognize the need to make the change, but may require assistance in arriving at the decision whether it is worth the effort. Success depends entirely on the individual's sincere desire to develop the use of this hand.

Perhaps the greatest assistance that can be offered by the dominant-handed instructor is to demonstrate his own more or less successful efforts to use his other hand. The replacement must also be carried out without emotional pressure or disciplinary measures of any kind which might give rise to resistance and cause traumatizing mental conflict.

The question may be asked, Is it not harmful for a left-handed person to attempt to develop right-handed patterns of action?

It would seem from observation and intimate knowledge of handicrafts as performed by both right-handed and left-handed persons that this is more than an open question. Personal experience has led to the belief that, provided the challenge is accepted with an open mind and a whole-hearted willingness to make the change, no harm can be done the left-handed person by an understanding effort to develop the use of the right hand. This is predicated upon the student's willingness and real interest in developing and using the right hand. Success can be more easily assured at first by using activities or techniques unknown to the student, so that here new action patterns are being learned for the first time. This will present the left-handed person no greater degree of difficulty than is experienced normally by the right-handed person in undertaking certain craft techniques for the first time.

As noted above, there are many activities that require the right-handed person to develop the maximum skill and, in some instances, physical strength in the weaker left hand. No one would think of suggesting that this deliberately undertaken self-discipline is a traumatizing mental experience for the right-handed worker.

The enumeration of a few of these activities will enable the reader to make his own observations and evaluate them in the light of the foregoing.

Women's clothes are all planned to button from right to left, thus requiring use of the left hand. All jewelry for women requires that catches be fastened with the left hand. This is universal for both right- and left-handed women. When clothing and jewelry were first developed, the wearers belonged to the class that had maids. Therefore, these objects were designed to be convenient for the right-handed maid. This pattern of construction was so fixed and established before women in every walk of life began to wear organized clothing and jewelry that the order of construction has not been changed. Therefore, both right- and left-handed women button and hook dresses and coats and snap the catches of jewelry entirely with the left hand. Would any one suggest that the use of left-handed clothes and left-handed jewelry by the modern right-handed woman is a traumatizing experience that causes her to feel insecure?

The right-handed student of the piano must not only develop a new skill, but must coördinate this with a degree of strength that is also new to his left hand. And should he be left-handed at the time of undertaking his study of piano technique, he has no advantage, for he must develop a similar skill and strength in his right hand, which until then he has not possessed. The violin, too, requires the right-handed player to use his left for the most delicate of operations, the fingering. While there are left-handed violins, very few left-handed musicians ever use one. Many wind and percussion instruments require equal skill, dexterity, and even strength in both hands.

Certain handicrafts require either equal skill in both hands, or the development of the real skill in the left hand of the right-handed person, or the right hand of the left-handed person. Repoussé and chasing are examples of the foregoing. The tool is held in the left hand of the right-handed person and guided to produce minute lines and delicately modeled surfaces on metal. The tool is controlled entirely by sense of touch; neither the end of the tool nor the result on the surface of the metal can be clearly seen, because they are hidden by the worker's hand. The right hand of the right-

handed worker is used simply to strike blows with the chasing hammer upon the head of the tool, giving it continuous pressure. Should the student be left-handed, he takes over the more delicately skilled phase, the guiding of the chasing tool, with his right hand and uses the hammer in his left.

The right- or left-handed engraver holds the gravers in the favored hand, but must develop sensitive coördination in the other hand, which is used to turn and guide, with hair-splitting precision, the block to which the work is cemented. The right-handed golfer must power the swing of the club with a back-hand stroke of the left hand, while the right hand only follows through and helps to guide the stroke.

The real baseball fan may evaluate the degree of coördination required in both hands and arms in batting and pitching, but it is worthy of note that some players pitch right-handed and bat left-handed, while others are left-handed pitchers, but right-handed batters. Some bat with one hand against a right-handed pitcher and with the other hand against a left-handed pitcher.

A therapist of many years experience who personally has trained and supervised the teaching of knitting said that she does not recall a single left-handed person who ever used the left hand when knitting and purling, the skillful part of the technique. All knitting instructions are planned for right-handed knitters. The technique could be translated into a left-handed activity, but a right-handed instructor who had not given the matter much previous thought would have great difficulty in demonstrating left-handed. The point is that both right- and left-handed patients, in learning the new pattern of knitting for the first time, developed the required skill with equal ease in only the right hand.

Many machine tools that require the use of both hands are planned for dominant right-hand control and cannot be successfully operated unless skill can be developed in the right hand by the left-handed worker.

The engineer who drives a powerful steam locomotive occupies a position on the right-hand side of the cab, which requires him to use his left hand, even though he be right-handed.

Horseback riding and driving tradition require the right-handed person to use the left hand to hold the reins, and through more or less delicate manipulations of these, to convey

his wishes and maintain control. The right hand holds the little-used whip or riding crop.

Driving a car requires use of both hands and feet, regardless of right- or left-handedness. The king of instruments, the pipe organ, requires the use, equal skill, and coördination of the player's two hands and two feet, with delicate touch- and time-controlled operations.

The above are but a few of the activities that require the adult to learn a new pattern of action with the less-favored hand or with both hands. They would seem to indicate that new patterns not previously formed by either hand can be relatively easily acquired by either hand, even though the person be left- or right-handed. This presupposes that the left-handed student is willing to accept the challenge, with a desire to coöperate and to make the change. The above would also seem to indicate that much of the pattern of ordinary right- or left-handedness which is acquired during the formative period is environmentally conditioned and can and should be easily guided and controlled.

RESURRECTION *

HELEN AUGUSTA RANLETT
New York City

"HAIL, Caesar! We who are to die salute you!"
Thus back in heartless Rome the greeting ran
When for the cruel pleasure of the crowd,
As beast killed beast, so also man slew man.

We who *have* died salute *you!* For we speak
Even as fallen gladiators, we who know
The bitterness of battle undesired,
Bewildered struggle, and then, overthrow!

But what if death may bring a resurrection?
After the grave has brought surcease of strife
The powers of healing touch the shattered spirit,
And in the darkness stirs the seed of life.

Reborn, we walk again among our fellows;
Bearing rich fruits, we come prepared to give
A deeper knowledge and a warmer kindness,
And we salute you, we who are to live!

* Written for the first anniversary of the W.A.N.A. ("We Are Not Alone") Society, an association of former mental patients whose aim is mutual help and encouragement and the promotion of a sense of fellowship among all those who are or have been mental patients.

THE CLERGYMAN COÖPERATES WITH THE PSYCHIATRIST *

THEODORE F. ADAMS
Pastor, First Baptist Church, Richmond, Virginia

MINISTERS and psychiatrists are realizing more and more that they have much in common and that there is a very real relationship between mental hygiene and religion. Both professions are dealing with the same people and are concerned with common problems. Both seek to help men and women who suffer from a sense of guilt and who are overwhelmed with the frustrations, disappointments, and failures of life. Each must deal with fear, with the sense of inferiority, inadequacy, and insecurity, and the desire for love, recognition, and assurance that is common to mankind. They are concerned with such special problems as alcoholism, as well as the whole gamut of human relationships, personal and familial, marital and social.

To these problems each has a contribution to make, and both can profit from coöperation. The minister, as a man of faith, must recognize the validity of science and must learn and profit from scientific studies and methods. The doctor, as a man of science, does well to recognize the contribution of religious faith to life and to use some of the values of religion in his practice.

Certain factors must be borne in mind in this relationship between the minister and the psychiatrist. First of all, the minister must recognize that he is not a psychiatrist and that he need not be. He has his own field of service, and it is important that he be at his best in that, but that he learn when to refer patients who need skilled professional or institutional care. The psychiatrist must recognize that he often needs the aid of religion if he is to meet the full needs of his patients. The minister, in turn, will do well to urge patients and families to consult psychiatrists. Often he can help his parishioners to accept the necessity of institutional care, either for themselves or for those they love.

* Presented at the Thirty-eighth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 12, 1947.

The minister has a threefold function in mental hygiene. He is, first of all, a detector. He should be alert to note in his people signs of stress and tension such as excessive and unwarranted emotion, withdrawal, compulsion, and self-recrimination.

The minister's second function is that of counselor. He should make every effort to learn how best to counsel as a pastor. Dr. Otis Rice states that the aim of pastoral counseling is, "To discover the internal tensions and external pressures with which our parishioner is struggling; to evaluate his capacity for dealing with these tensions and pressures; then, without removing his personal responsibility, to help him marshal his capacities and resources (social, personal, and religious) so that he may relieve these pressures to the point where, with an understanding of his situation, he is able to deal with them creatively himself."

The minister also has to function in the field of prevention. His is the task of developing the right kind of people. He must help to grow individuals who have "health of soul" and right attitudes toward life. He will encourage personal prayer and meditation and seek to develop integrated lives of trust and inner peace.

Religion has much to contribute in the realm of mental hygiene. It helps the individual to develop a personal faith that makes him adequate for life and all its tests. The church, as an institution, is of incalculable worth. Its "Communion of Saints" offers a feeling of significance to humble and otherwise monotonous lives, and a chance for fellowship and service to those who feel that their lives do not count. The experience of worship brings a sense of the presence and strength of God to lives that otherwise might be weak and irresolute.

The Christian faith not only helps individuals to get away from such harmful attitudes as infantilism, selfishness, and avoidance of responsibility; it seeks also to cultivate positive attitudes of love, good will, and brotherhood.

Recognizing the basic need of every individual for love, significance, and security, the minister points out that these can best be attained fully through religion which portrays the infinite love of God and offers a true sense of personal adequacy to every individual as a child of God and a worker

with God. Religion also teaches that true security is to be found only through self-control, self-appreciation, and self-giving.

The minister himself has a real function in helping individuals to face the crises of life. He is close to the individual and the family in nearly every one of the great hours of life—birth, conversion, adolescence, marriage, maturity, and death. As a wise pastor and counselor, he can help develop the qualities of faith that help many come through these often difficult hours stronger and better. In his counseling before and after marriage, the minister is able to help develop enduring homes and happy relationships, out of which better balanced children can come, with their own promise of a better future.

The wise pastor will learn much from the psychiatrist and from leaders in the realm of mental hygiene. From them he can obtain a better understanding of mental and emotional ills and seek guidance and coöperation in cases that are beyond his own skill or function. He will seek help in the training of parents and teachers in his church school, that they may be better able to deal with the emotions of children and guide their growth aright.

Each serving in his own distinctive field and yet both working together as they deal with the common problems of the same people, the minister and the psychiatrist should coöperate as never before in the name and the spirit of the Great Physician Who, long ago, "seeing the multitudes, had compassion on them" and said, "I am come that they may have life and have it to the full."

THE WASHINGTON CONFERENCE OF CLERGYMEN AND PSYCHIATRISTS*

ROLLIN J. FAIRBANKS

Executive Director, Institute of Pastoral Care, Boston

NEARLY two years ago, Dr. Robert A. Clark, Clinical Director of the Western State Psychiatric Institute in Pittsburgh, suggested that it would be helpful to have a conference of clergy and psychiatrists who were concerned about mutual problems. Conversation and correspondence with other interested persons confirmed this suggestion, and in March, 1947, such a conference was held at the College of Preachers in Washington. It was sponsored by the Institute of Pastoral Care, in coöperation with The National Committee for Mental Hygiene, the Commission on Religion and Health of the Federal Council of Churches of Christ in America, the Council for Clinical Training, and the Massachusetts General Hospital.

A planning committee, consisting of both psychiatrists and clergymen, organized the details of the conference. It was agreed, for instance, to accept certain necessary restrictions in order to be able to concentrate upon the subjects for discussion. These restrictions provided, first of all, that attendance be limited to clergymen and psychiatrists, although it was recognized that social workers, clinical psychologists, lay analysts, and even directors of religious education were equally concerned with the relationship of religion to psychiatry.

Although science is not denominational, it was recognized that some scientists are. We realized that our deliberations would not be concerned with pure science, but rather with science as interpreted by minds that have been influenced by certain cultural heritages. In order to minimize differences, therefore, attendance was restricted to Protestant clergy who had had some clinical training in understanding human nature or who were devoting a large portion of their time to ministry to individuals.

Psychiatrists, likewise, were selected on the basis of their

* Presented at the Thirty-eighth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 12, 1947.

Protestant background and their genuine interest in (although not necessarily acceptance of) religion. In other words, while no orthodoxy was sought, it was acknowledged that a minimum of cultures would assure a minimum of digressions or distractions from the subjects to be discussed.

In order to provide for complete identification with the conference, it was arranged that each topic would be presented both by a clergyman and by a psychiatrist. The speakers were urged to base their remarks on actual clinical observations instead of indulging in excursions in speculation. Because of all these provisions, there was a remarkable and unique concentration upon the program itself.

The *first* topic dealt with "Procedures of Coöperation Between Clergy and Psychiatrists." Similarities and differences were pointed out. So-called "therapeutic imperialism" was decried in both professions. The value of consulting instead of always seeking to transfer the individual from one profession to another was indicated. The wisdom of employing multiple relationships in a program of therapy was stressed. The nature of bereavement was discussed thoroughly, since it constitutes one of the most obvious situations in which both professions can make contributions.

The *second* topic was "How the Clergyman and the Psychiatrist Can Aid Each Other in Counseling on Marital Situations." The increasing load of marital problems was acknowledged by both professions, as was the importance of pre-marital counseling. Preparation for marriage, it was pointed out, begins not with late adolescence, but during the individual's childhood, when concepts of marriage and attitudes toward sex are being acquired. These early ideas frequently survive any superimposed indoctrination—even on the college level—and return to jeopardize marital adjustments. Once again it was recognized that both professions were dealing with a joint problem.

The *third* subject was greeted with considerable hopeful anticipation. Both professions were desirous of further enlightenment. The title was "The Respective Functions and Limits of the Clergyman and the Psychiatrist as Counselors." If these areas could be marked off and clearly labeled, then the matter of trespassing would be settled once and for all.

Ironically and inevitably, no such Solomonic decision was reached. We were reminded of the futility of leading horses to water when there is an unwillingness or a determination not to drink! In other words, the patient or parishioner often has preferences or prejudices as to whether he desires psychotherapy or spiritual guidance. Another determining consideration that was brought out was the question, who has the best relationship, since therapy as such is undeniably dependent upon rapport. There was no question as to who should function when "severe disorders" were involved. On the other hand, it was also acknowledged that many clergy serve in isolated areas where actually no psychiatric assistance is available.

On the morning of the second day, we gathered in the small chapel for a brief meditation service which was conducted with rare sensitivity for and understanding of human nature. Our leader was the Bishop of Washington, who pointed out that man's needs are seemingly paradoxical. He wants to reveal and yet to conceal. He seeks to bare his soul to God and also to escape the scrutiny of God. Man has a deep need to belong and a yearning to be reconciled with himself, with his fellow man, and with God. Those of us who attended came away from the chapel deeply moved that so much sound understanding of the very purpose of the conference could be incorporated so fittingly into a devotional service.

The *fourth* topic was perhaps the most provocative in the entire series. It dealt with "The Relation of the Counselor's Philosophy of Life to His Therapeutic Results." In other words, does it make any difference what we believe, when we seek to provide professional therapy?

I wish that I might report some profound conclusions. Actually all that we were able to do was to "scratch the surface," so to speak. Both professions acknowledged that greater consideration must be given to the place of values in a therapeutic relationship. At the same time it was pointed out that it is sometimes difficult to ascertain what an individual's actual values are. Until comparatively recently, psychiatry has been primarily concerned with a descriptive approach. Clinical experience to-day, however, has made it obvious that values can no longer be ignored either in understanding or in treating the patient. The clergy, on the other

hand, have become increasingly aware of a wide variance at times between those values that have been accepted intellectually and those that are actually motivating behavior.

The *fifth* subject was "Methods of Coöperation on the Educational and Preventive Aspects of Mental Health." It became obvious both from the presentations and from the discussion that the two professions need to share more, as well as to coöperate, if a sound educational and preventive program is to be realized. As one psychiatrist pointed out, both the clergy and the psychiatrists should take as their goal the development of as many emotionally mature and intellectually informed adults as the limitations of human nature and the scarcity of trained leaders permit.

The last subject was "Joint Research: Desirable or Possible?" One of the difficulties in comparing the experiences of the two professions is the scarcity of tangible, clinical evidence in the pastoral field. The experimental approach is still rare in theological study, while, on the other hand, it is essential to psychological study. Joint research is desirable and needed; mutually acceptable methods, however, have yet to be fully developed.

Even from a perspective of eight months, it is still difficult for those of us who attended the conference to be completely objective in any evaluation that we might attempt. The gathering was so significant and characterized by such a splendid spirit that we cannot yet wholly remove ourselves from it. Despite this limitation, however, certain things stand out.

First of all, there was throughout all the deliberations a note of sincerity. There was a genuine desire for the truth, wherever it might be found, which was stronger than a natural defensiveness. At first some restraint was apparent and inevitable as forty strangers gathered in an unfamiliar place to attempt something that had not been done before. Soon, however, this was dissolved by the contagious enthusiasm and the eagerness with which we all moved from topic to topic.

Both groups wrestled with the problem of denominationalism. For some of the clergy, for instance, the sacramental approach was more meaningful than for others. Among the psychiatrists, there were psychoanalysts and those without that training and experience. There were disciples of Freud

and followers of Jung. Static and dynamic schools of psychology were represented. Despite these differences, however, there was complete agreement as to the focus of the conference.

In retrospect it would appear that theology failed to contribute as much as it might. Those of us who represented religion demonstrated an understanding of psychiatry, but perhaps we offered too little of our own unique resources. We emerged from the conference rather in the rôle of allies than of contributors. The psychiatrists, on the other hand, shared generously of their insights, but revealed only a vague and somewhat theoretical understanding of just what the minister does.

The net result of all this has been a conviction on the part of both professions that we must "go on" from here. We have started something that demands continuation. The direction of further deliberations would seem to me to move beneath specific areas of coöperation and explore jointly basic concepts. This probably could not have been done at the first conference because we had not yet achieved a mutual respect rooted in a joint project. Now that this is ours, however, we can dispense with the introductory formalities and courtesies and plunge into the deeper waters wherein life takes on a new dimension.

For the psychiatrists this will perhaps mean inviting criticism and misinterpretation, particularly from within their own ranks, for actually it will involve "walking on water," so to speak, in the sense that many tangibles will of necessity be left on shore. For the clergy, on the other hand, it will mean admitting into the "holy of holies"—into a hitherto private preserve—a group of men and women who are, to all practical purposes and training, "from Missouri." Needless to say, given these conditions, something is bound to happen. Either new light will appear or confusion and possibly disillusionment will follow.

What are some of these basic questions that deserve and *need* joint consideration? First of all, there is the question of the concept or nature of man. Is he victim of a deterministic process whereby early experiences determine later deci-

sions? Or does he actually possess a free will? Have we conclusive clinical evidence to support either premise?

Are values but rationalizations of our desires? Or are they external realities that we inherit or otherwise acquire? Are there absolute values? What is the relationship between behavior and values?

Moving back toward shallow water, we find that there are two relevant subjects that deserve further consideration. The first is the matter of the relationships of the psychiatrist and of the minister to people in trouble. Are they the same? Or is there something unique about a therapeutic relationship? Is there also something quite different about a pastoral relationship? Perhaps they are not as similar as we have assumed. If not, then this should have significance when we move on to the second subject and consider methods.

Textbooks on psychiatry continue to be vague as to the actual content, the specific techniques used, in psychotherapy. Psychiatrists themselves are not excessively garrulous on this subject. Likewise the few textbooks on the pastoral relationship are equally vague. Aside from the use of sacraments, scripture, and prayer, are all the other tools—such as suggestion, persuasion, education, interpretation, and so on—identical for both professions?

Looking back upon what was attempted and reviewing what still needs to be done, I am wondering whether possibly we are naïvely walking "where angels fear to tread." It may well be that we are dealing with highly inflammable, if not actually explosive, material. Certainly isolation is not the answer and neither is orthodoxy. The late Dean of St. Paul's, London, once commented that "in order to be perfectly orthodox, one must not think at all!"

May I take the liberty of closing my remarks with a deeply sincere and prayerful (if you will) observation? As a Christian citizen, not only of this country, but of the whole world into which we are now so inextricably woven, it is my profound hope and desire that the insights of psychiatry into human nature can be combined with the aspirations and values of religion, so that we *can* achieve a better life (in a non-material sense) "on earth as it is in heaven." We who are privileged to be parents—and many others to whom that privilege has

been denied—yearn to bequeath to our children a better world than that into which *we* were born.

It *can* be done. The National Committee for Mental Hygiene is dedicated to that cause. This annual meeting is indirectly commissioning us to *do* something about it. I believe our Washington Conference has made its small contribution. It is my hope that it will be followed by others, national and regional, so that its leaven may be distributed throughout our nation.

CLARENCE O. CHENEY

DR. CLARENCE O. CHENEY died in White Plains, New York, on November 4, 1947, of a cerebral hemorrhage which occurred while he was asleep. Thus ended the career of an outstanding worker in psychiatry.

Dr. Cheney was born in Poughkeepsie, New York, in 1887. He was graduated from Columbia College in 1908 and from the College of Physicians and Surgeons in 1911. His fellow students recognized him as a man of unusual ability. The same year he joined the staff of the Manhattan State Hospital, and for several years was its pathologist. Then he became assistant director of the State Psychiatric Institute, which in those days had wards and laboratories in that hospital plant. In 1922 he went to Utica as assistant superintendent. This position had been created in that relatively small hospital because nine miles away a new institution was growing in Marcy. Dr. Cheney, under the direction of the late R. H. Hutchings, therefore spent most of his time in developing what later became the Marcy State Hospital. Here his administrative capacity had scope, while at the same time in the parent institution he kept in touch with all scientific developments and continued his special studies.

In 1926 he was appointed superintendent of the Hudson River State Hospital at Poughkeepsie. It was pleasant to be back where his childhood had been spent, but though a man of social nature, his professional work was always his principal activity and probably the source of his greatest satisfactions. In 1931 he was called to the directorate of the State Psychiatric Institute, which had moved from Ward's Island to the Medical Center. Relatively seldom in this country has the head of a large hospital been called on to drop its many interesting and pressing activities and take charge of a program of teaching and research, but Dr. Cheney's intellectual and temperamental equipment for that post was immediately recognized, and for five years he directed the broad program of that institution.

The Society of the New York Hospital draws many of its ablest physicians from the New York State service, and it

was quite logical that when, in 1936, the position of medical director of the Westchester Division needed to be filled, Dr. Cheney should be invited to that post. There he expanded the programs of teaching and training of physicians and various types of staff members. That hospital like others suffered from the stresses of the war period and its burdens were heavy, but Dr. Cheney, in spite of some warnings about his physical health, remained at his post until the end of June, 1946, when he retired.

While stationed on Ward's Island, he held a teaching post in Cornell Medical School and during the war also taught in New York University. At Utica he was a member of the medical faculty of Syracuse University. While director of the institute, he was professor of psychiatry in Columbia and on his removal to White Plains, he became a professor of clinical psychiatry in Cornell. He was an original member of the American Board of Psychiatry and Neurology. In 1935 he became president of the American Psychiatric Association, having already served four years as secretary and treasurer. He was a member of psychiatric organizations where he lived and elsewhere (including England) and frequently was called on to serve as committeeman or officer. He was a Fellow of the American Medical Association and of the New York Academy of Medicine, and for years was an associate editor of the *American Journal of Psychiatry* and of the *Psychiatric Quarterly*. He held membership in the honorary societies Sigma Xi and Alpha Omega Alpha. In 1944 he was awarded the Columbia University medal for professional distinction and public service. He served on various committees of The National Committee for Mental Hygiene. On various occasions he did service for his state and the nation. His social life included a national fraternity, a service club, and the University Club of White Plains. In 1915 he married Josephine Scott, who survives him, with a son, Robert Scott Cheney.

Dr. Cheney's opinion was always listened to with respect. He was a forthright man who could be expected to reason directly to the center of any controversial matter. He did not hesitate to side with a minority, but after presenting his argument, was likely to find the majority agreeing with him. He had a healthy distaste for vapid verbalization and

maintained a challenging attitude toward medical theorization, but was enthusiastic when his opponents could stoutly maintain an opposite opinion. His colleagues recall his meticulous administration of the institutions that he served, and those who were closest tell of his readiness to modify standard procedures in order to help people in difficulties, of his immediate attention to those who brought him their personal problems, and of his kindness to those in trouble. His business judgment was most valuable to the medical organizations in which he held office. As a teacher he quickly established rapport with his students and presented material so that it was remembered for years. It fell to him to give medical care to some of his outstanding colleagues who perhaps would have been impatient with any physician whom they respected less.

The titles of his papers and the substance of his official reports range all the way from brain changes in dementia præcox to the psychiatry of mythology. His revision of outlines for psychiatric examinations is used in mental hospitals throughout the land.

It was no secret to Dr. Cheney that by inheritance and constitution he was liable to arterial accident. Such accidents came and gave him a natural amount of concern, but he was not one to shirk duty because of temporary incapacity. Until late in his life he participated in vigorous sports, and indeed resumed playing tennis when a timorous man would probably not have dared to. As a patient he was loyal, but when given a choice of activity or inactivity, it was natural for him to do rather than to be passive. Retirement was for him only a lessening of intellectual and social activity, by no means a discontinuance. Happily, he was permitted to maintain this activity up to a few hours before the final incident.

SAMUEL W. HAMILTON

BOOK REVIEWS

SEXUAL BEHAVIOR IN THE HUMAN MALE. By Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin. Philadelphia: W. B. Saunders Company, 1948. 804 p.

By now, nearly every one who reads MENTAL HYGIENE probably knows about the Kinsey study, for few scientific books have ever received the attention accorded this book. Even before publication, it was widely acclaimed by the popular journals. On reading the book, one understands why. One cannot but greatly admire Professor Kinsey's perspicacity in choosing so significant a problem; his skill in formulating his problem and his originality in shaping his techniques; his perseverance in collecting his cases, especially in the early stages of the project, when he was working alone, without organized support; his honesty and humility in presenting his findings; and his humanitarian concern with the social significance of his results.

In all the literature on sex, there are, states Kinsey, only 19 previously published studies that may be called scientific. These studies, involving coverage of the same items for each case and careful statistical treatment, are reviewed by Kinsey in Chapter I. The most extensive of them, the Hohman-Schaffner study (1947) of army inductees, covered only 17 items, compared to the 521 possible items of the Kinsey entry. The findings of the former study are of questionable validity because of failure to hold constant such factors as the educational level of the subjects. A few of the earlier studies provide generalizations which may be valid for one group only, college students, whereas Kinsey claims that his findings are valid for the 163 groups on which data are given.

Readers of MENTAL HYGIENE will be interested in some of Kinsey's principal findings. Any list of this kind represents, of course, a selection and reflects the reviewer's judgment as to what is important. The reference in the following is to the white male in the United States.

1. The incidence of sexual experience in the human male is greater than has been previously thought, at least as regards certain outlets. Masturbation that leads to orgasm is practiced at one time or another by 92 per cent of the male population, with a peak frequency in early adolescence of 2.4 times a week. Heterosexual petting is indulged in by about 88 per cent prior to marriage, with 28 per cent of the males reaching orgasm. Premarital intercourse has been experienced by 73 per cent of all males by the time they reach the age of twenty. Intercourse with prostitutes ultimately involves 69 per cent of the

white males. About half of all married males have intercourse with women other than their wives at some time while they are married. Homosexual contacts resulting in orgasm are reported by 37 per cent.

These are accumulative incidence figures; that is, they indicate the per cent of the population that is ultimately involved in the given experience. Frequency of experience is another matter, which cannot be reported here because of lack of space. Kinsey points out that American law makes illegal all premarital sexual activities except nocturnal emissions and solitary masturbation, and he calculates that at least 85 per cent of the younger males could be convicted as sex offenders if the laws were perfectly enforced.

2. Age is the most important single factor affecting sex behavior. The ability to experience orgasm exists at a very tender age, and has been obesrved in boys of every age from five months on. Kinsey finds no evidence of any pregenital stage of generalized erotic response, and no latency period, contrary to the Freudians. The ability to have repeated orgasms is greatest in pre-adolescents and decreases with age. The peak of sexual performance occurs at sixteen or seventeen years of age, and then tapers off. Age at first orgasm is correlated with sexual vigor.

3. After the first complete sexual experience, practically all males become regular in their sexual activity. Multiple outlets are typical, the mean number between two and three.

4. There is great individual variation in total outlet. One male reported only one complete sexual experience in thirty years, another ("a scholarly and skilled lawyer") 30 orgasms a week for thirty years, a difference of 45,000 times.

5. Sexual behavior varies greatly by educational and occupational classes. Unmarried males who have not gone beyond grade school find their principal sexual outlet in sexual intercourse, which they regard as natural, and they tend to hold masturbation in contempt as unnatural; whereas the college group gets its principal expression via masturbation and heterosexual petting. Between the ages of sixteen and twenty, 85 per cent of the grade-school males have had premarital intercourse, compared to 42 per cent of the college males. The data on frequency are even more striking, the grade-school boys having seven times as much premarital intercourse as the college boys, for whom the experience is often only episodic.

Prostitution also is largely a function of non-college groups. Lower-class men are less faithful to their wives at the time of marriage, but become more faithful with age; college men are more faithful at first, become less faithful with age. Kinsey thinks this may mean that the grade-school group, having had its fling early, tires of variety and settles down; whereas the college group, held at first to more rigorous

observance of the monogamous *mores*, wonders what it has missed and hankers after variety.

The rejection of nudity by the lower classes and its increasing acceptance by the higher classes is reported. The lower classes also eschew the foreplay (oral and manual stimulation) which the marriage manuals have taught the college group to regard as advantageous. Yet the most striking report is that grade-school females, without benefit of "the art of love," have more frequent orgasms. Fuller details on the latter point will doubtless appear in the report on sexual behavior in the human female, which is to appear next in the series of a dozen or so volumes that Kinsey contemplates issuing.

6. The relative stability of sexual behavior in the last two generations is remarkable, attesting, Kinsey thinks, to the power of the *mores*. Holding the educational factor constant, Kinsey compares two groups, the median age of the one being 43.1 years, of the other, 21.2 years. The older group was in its youth in the years from 1910 to 1925, the period characterized as the "roaring twenties"; most of the younger group was in its prime from 1930 on. Comparison of the accumulative incidence curves shows that the number of persons ultimately involved is much the same in the two generations as regards the following types of behavior: heterosexual intercourse, premarital intercourse, homosexual intercourse, and intercourse with prostitutes. Changes include: (1) the larger number of the younger generation involved in masturbation and petting; (2) the younger generation of the lower class active a year or two earlier in heterosexual and premarital intercourse (Kinsey's explanation being that the lower social level's adolescence has been advanced a year of so because of improved nutrition and health, the upper classes showing no such change because they have always enjoyed the benefits of good nutrition and medical care); (3) a percentage of premarital intercourse transferred from prostitutes to girls who are not prostitutes.

A scientific study should be viewed critically, for criticism is essential to scientific progress. When a work has as much social significance as Kinsey's and is the recipient of such widespread acclaim, it is especially imperative to examine it with the greatest care.

The big question, therefore, is: How valid are the Kinsey findings? A chapter of the book is devoted to this question—Chapter 4, *Validity of the Data*, which turns out to be mainly an inquiry into the reliability of the data. Eight different tests are employed to measure the tendency of interviewees to give consistent answers to the same question. Retakes after an interval of from eighteen to sixty-four months showed that the incidence data are the most consistent, while the frequency data are less reliable. All in all, the several tests indicate that the recorded testimony is relatively consistent and stable.

Still, an important question remains. Can we, on the basis of the sample interviewed, generalize about the behavior of the group represented? Can we talk about the sexual behavior of "the college male" on the basis of the college men who participated in the study? The answer to this question depends on the representativeness of the college sample that participated, and we do not know that the sample is representative of college males generally. For the most part Kinsey depends on volunteers and most of his data are partial samples. Where he does have a few 100-per-cent samples (all the members of a fraternity being interviewed, for example), social pressure is required to get the reluctant ones to coöperate, which may affect their testimony. But even if all the members of a fraternity "coöperate," how do we know that this fraternity is like other fraternities in respect to sexual behavior? The use of volunteers unavoidably results in selection, and we have not much knowledge of how those who do not volunteer their histories differ from those who do. That there are important class differences in willingness to give sexual histories, Kinsey mentions a number of times, acknowledging that he has encountered the greatest reluctance among older married males of the higher educational and social levels.

Another important set of questions has to do with the validity of the responses. How accurately do the replies reflect actual behavior? Here there are at least two problems—the problem of the accuracy of recall and the problem of possible resistance and emotional block. Because boys recall with considerable accuracy the age at which they developed certain physical traits associated with adolescence, it does not follow that they can with equal accuracy remember the details of their sexual behavior. There are probably class differences in the accuracy of recall, just as in sexual behavior itself, but with these basic psychological problems this study does not concern itself.

Fully as important must be the problem of resistance where anything as highly controlled by the *mores* as sex behavior is concerned. We can understand how an individual who is troubled by his sex history may unburden himself to a psychiatrist, in the hope of getting help from him. But is the satisfaction of contributing to a scientific study motivation enough in such cases? The fact that so many persons did contribute information that is personally damaging, from the standpoint of the *mores*, is cited as an indication that the subjects were probably telling the truth. It remains only a matter of probability, unless checked against actual behavior. Since direct observation is not feasible, Kinsey has probably done the best that can be done. But from the standpoint of rigorous scientific method, we should not lose sight of the fact that it is not good enough.

Readers of MENTAL HYGIENE may well ask what the social signifi-

cance of Kinsey's study may be. What does it mean and what will it accomplish? These are big questions which can be answered here only in a very small way. The fact that Kinsey was able to complete so comprehensive a study may perhaps be taken as evidence that important changes are occurring in the *mores* of sex, at least in the direction of a lessening of the taboo on discussion of intimate sexual questions. This study probably could not have been undertaken two decades ago.

Kinsey finds that the sexual *mores* have remarkable stability, as evidenced by the similar sexual behavior of the two generations he studied. If two world wars, two depressions, the introduction of the automobile, and the spread of artificial contraception have not materially altered the sex *mores*, how much difference should we expect Kinsey's book to make? This is a difficult question to answer, but it may be observed that changes in the *mores* must in the nature of things be gradual, especially as regards anything so imperious as sex, in the interests of social stability, as witness the disorganization that results when the sexual *mores* are upset in social revolutions, like that of the Bolsheviks. There is stability in the sex *mores*, but change, too, and if one wishes, one could emphasize the latter rather than the former, as Kinsey does, especially the increasing premarital intercourse of "good girls."

Since there is change, the Kinsey book may contribute to the trend, for it reveals more completely and devastatingly than has ever been done before the unreality of many of our institutional sanctions and prohibitions regarding sex—for instance, our repressive policy with respect to homosexual behavior, especially in prisons where the high incidence of the behavior raises questions as to what constitutes "normal" behavior under the circumstances.

There is evidence that our sexual ethics cause untold unnecessary misery. The Kinsey study does not and cannot in itself provide us with a more realistic social policy regarding sex behavior, but one may surmise that it furnishes us with data on which to base a sexual ethic better suited to the biological nature of man.

M. F. Nimkoff.

Bucknell University.

Sex Problems of the Returned Veteran. By Howard Kitching. New York: Emerson Books, 1946. 124 p.

In spite of the title of this book, it is primarily concerned with marriage, the rôle of each partner while separated, and finally the problems that follow reunion. Though specifically designed "for those who recognize that there are perplexing problems to face and are pre-

pared to work to find a solution," it appears to this reviewer that what is stated in the book is fairly evident.

A great deal of stress is placed on the definition and constant repetition of the term "separation anxiety," with complete underemphasis both on the environmental and on the moral changes that any group of veterans in World War II faced, plus their previous underlying neurotic problems.

On page 35 the author states: "Separation gravely threatens the 'us' which is the creation of marriage and which is vital to it and to both partners. It threatens both the feelings of emotional security and companionship, and physical and emotional satisfaction of the sexual appetite, which are inseparably bound up with the 'us.' Therefore, anxiety follows. Because the 'us' and its benefits are largely unconscious, the individual is aware of unpleasant anxiety, but not of its source. He is handicapped in dealing with it just as a blindfolded man is handicapped in fighting an enemy who can see."

With the exception of this untenable statement—untenable because separation anxiety is largely conscious and only later becomes intertwined with basic neurotic character patterns—the book plainly and simply serves as an exhortation to the marital partners to work with good will and effort to maintain a marital adjustment

The book adds little to those already published on problems of marriage adjustment. It certainly contains little of specific import for veterans.

MAURICE R. FRIEND.

Jewish Board of Guardians, New York.

THE MARRIAGE READER; A GUIDE TO SEX SATISFACTION AND HAPPINESS IN MARRIAGE. Edited by Samuel G. Kling and Esther B. Kling. New York: The Vanguard Press, 1947. 489 p.

Love being one of the most interesting subjects in the world, it should not be hard to collect written observations on the topic. The anthology under review, *The Marriage Reader,* proves, very happily, that it can be done.

The worst that can be said for a publication of this type is that a certain amount of repetition may enter in, and also that the reader will on occasion have the feeling that he has read this before somewhere, or that he knows it anyhow.

On the credit side, two good features are apparent. The first is the very broad approach adopted in the book, which permits it to apply to almost any one's situation. The more philosophical sections are particularly thoughtful and stimulating. The second contribution—and that which will certainly receive most attention from

the reader—is the series of sections given to a reasonably exhaustive and almost clinical description of the sexual art in its various manifestations.

The book tries to be and is graphic and helpful. The thesis would appear to be that information that is readily available is needed in this field. And with abundant information, people are a good way along the road toward gaining the help that they need.

HOWARD G. PLATT.

Philadelphia.

NURSE-PATIENT RELATIONSHIPS IN PSYCHIATRY. By Helena Willis Render. New York: McGraw-Hill Book Company, 1947. 346 p.

This book was awarded the second of three prizes offered by the publishers in a series of nursing textbooks. In the preface, Mrs. Render states that "for the past twenty-five years the author has had the privilege of teaching and organizing courses in the field of psychiatry." Evidently hers was a labor of love. Techniques, procedures, and routines are not included. Emphasis is on the philosophies underlying the intimate nurse-patient relationship that exists in psychiatry.

The book consists of nine chapters and a four-part appendix. The first chapter, entitled *The Meaning of Psychiatric Nursing*, sets the keynote of the whole. It opens with a discussion of the patient and his needs, followed by an analysis of the general qualifications needed by a nurse to deal successfully with psychotic patients. Mrs. Render's sincere and sensible presentation indicates her broad understanding of patients and nurses, acquired during her years of experience as a nurse.

The principles presented by Mrs. Render are familiar to nurses who had their basic preparation in hospitals that offer education and clinical experience in psychiatry for medical, nursing, social-service, and psychological students. However, since the principles and attitudes presented are basically sound, they are applicable wherever patients are in need of care.

The chapters devoted to special problems presented by patients' behavior contain many extracts of actual records. These illustrate the point under consideration as well as more lengthy case studies could.

In addition to practical suggestions on the application of sanitation, hygiene, and psychology to the care of patients, Mrs. Render suggests methods of employing therapeutically the arts, literature, and music. An interesting outline for the study of Flaubert's *Madame Bovary* suggests a method of studying other books. Students will find the reading lists and references that follow each chapter helpful and valuable.

While the book was written primarily for nurses, others concerned with the care of psychiatric patients will find it of interest.

MARY E. CORCORAN.

U. S. Public Health Service, Bethesda, Maryland.

EDUCATING YOUTH FOR SOCIAL RESPONSIBILITY. New York: Community Chests and Councils, 1948. 37 p.

This, the sixth publication in a school-program series developed by Community Chests and Councils, is designed to bring a better appreciation of social problems to those who will in the near future be determining the shaping of our community services. The manual offers a wide range of suggestions for use in carrying through this project and, for the most part, the suggestions are helpful in utilizing the resources of the community for this purpose.

In part the manual follows the traditional patterns of education in terms of formulating information and presenting it to the student for absorption. In part it goes beyond this in the effort to involve the student himself in the activities of the community. This is all to the good. In some instances the involvement is that of a visitor, and in other instances, at a still higher level, it is the involvement of a student in actually making a contribution.

While the presentation brings together existing knowledge in a way that helps to solve problems, in this very process it also clarifies further problems of which we might otherwise have been unaware. For example, it is relatively easy to engage a student in the work of a community agency if he is interested, but what of those students who do not respond easily? That problem still remains to be solved.

There is also perhaps a tendency to make this too much of a program for youth alone rather than one in which youth functions in an integrated way with all ages.

Again, there may be a tendency at times to present the field of social work in the narrower sense, as it is conceived of in the American Association of Social Workers, rather than in the broader sense, as conceived of in the National Conference of Social Work.

Some questions are still to be answered, but the authors of this publication are to be congratulated on clearing the way ahead and opening up these other problems, even though they are as yet unsolved.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

PARENTS' QUESTIONS. By the Staff of the Child Study Association of America. (Revised Edition.) New York: Harper and Brothers, 1947. 256 p.

This book, originally published in 1936, had already proved itself a very real help to thousands of puzzled parents. The questions asked

by the many mothers and fathers who have attended the study groups of the Child Study Association are here answered in concrete, practical terms and illustrated by actual case studies, which show how various problems of discipline, health, and character building can be successfully met. A nice balance has been kept between the giving of first aid for the symptom presented and the giving of a deeper understanding of the relationships, feelings, and causes that may have brought about the problem in question. General principles are combined with illuminating source material. The original edition has been completely revised and two new chapters added.

One of these new chapters answers the question, "What is a problem child?" To parents who have had little or no previous experience with children and who are, perhaps, confused by a multiplicity of conflicting advice, this chapter will give some clear-cut criteria that will help them to determine whether or not their problem is one that needs the expert help of the trained counselor, social worker, psychologist, or psychiatrist, or whether it is one that is common to all children. It also tells them how they can obtain information as to where expert service can be found.

The other new chapter, *New Vistas for the Family—A Postscript*, discusses the dilemma of the family in our modern world, in which the emotional and psychic burden has been increased by the loosening of the "traditional picture of mother-always-in-the-house." New adjustments are necessary to meet the new patterns in family life as they emerge, and the authors offer thought-provoking suggestions for possible ways of using the new resources that are available without in any way lessening the fundamental strength of the family interrelationships.

A list of books for further reading is added.

JULIA MATHEWS.

Child Guidance Clinic of Los Angeles.

ADJUSTMENT TO PHYSICAL HANDICAP AND ILLNESS: A SURVEY OF THE SOCIAL PSYCHOLOGY OF PHYSIQUE AND DISABILITY. By Roger G. Barker, Beatrice A. Wright, and Mollie R. Gonick. (Social Science Research Council Bulletin 55.) New York: Social Science Research Council, 1946. 372 p.

This book is concerned with the "somatopsychological" problems of physically handicapped persons. Within the large field of relationships between physique and behavior, the term, "somatopsychological," is applied to purely psychological and social significances of physique. It considers, not the effects of behavior upon physique, nor the merely neuromuscular effects of physique upon behavior. It studies

"molar" activity, the individual's continuing flexible behavior directed toward a goal of adjustment; and it studies those physical traits which serve as a stimulus to the self or to others and which, therefore, have importance in social adaptations.

The book does two things in most illuminating fashion. It presents a critical survey of research already done in this realm and adds a theoretical basis for future more integrated study of the problems of adjustment experienced by physically handicapped people.

The mode of presentation of research data used here could well be a model for "surveys of the literature." Research articles are sorted topically in numbered "research summaries" at the end of each chapter. The essential data of each research are listed categorically, and critical comments evaluating the results are appended. The body of the chapter is then free to discuss the findings and to develop integrated conclusions as to what is known, or is still to be learned, about the subject under consideration. This procedure makes for completeness and clarity without the boredom usually found in surveys of research.

Physical variations that have somatopsychological effects are numerous. For intensive discussion, the authors have selected normal variations in physique, crippling, tubercular conditions, impaired hearing, and acute illness. They give selected bibliographies of somatopsychological research relating to these conditions and comparable bibliographies also for visual disability, cardiac disability, diabetes mellitus, cosmetic defect, rheumatism, and cancer. Gathered together here is a tremendous amount of valuable reference material for those who are studying any one physical disability.

The particular value of the chapter discussions, however, is not in the mere assemblage of data. It is in the critical appraisal of methods and tools used for research (surely after reading this book no one can have the conscience to use "personality" test and inventory "scores" uncritically!) and in the integration of results from many sources into meaningful (though most provocatively patchy) pictures of adjustment problems and the methods handicapped individuals have used for meeting them.

The book most successfully bridges the gap between research based upon case-study techniques and research that uses massed data and correlational techniques. Clinicians have long known that the correlational studies gave little help in understanding the presented patient and his individual collection of symptoms and adjustment devices. They have, on the other hand, had difficulty in deriving from their individual case studies laws or rules that would have validity beyond a few cases. It is by making sense of this tantalizingly rich, but rela-

tively undeveloped, no man's land between the two extremes that this book makes its greatest contribution.

From topological psychology, the authors apply the concepts of "new" and "overlapping" situations, "potency," "valence," and "barriers," to describe the situations in which a handicapped person finds himself and to illuminate the behavior that appears. Out of this theoretical approach develop positive hypotheses as to the social and psychological effects of variations in physique, hypotheses that may stimulate new clinical appreciations of individual cases and that may be subjected to experimental proof or disproof. Thus is opened a way to pertinent integrated research on some of the most complex problems in human adjustment, a way that sacrifices nothing of scientific method or of clinical richness and variability, a way that may lead in future to the filling in of many blank areas in our present understanding of why and how people alter their methods of meeting difficult situations.

Whether or not one accepts completely the theoretical background, the book is highly provocative of thought and discussion. It is to be hoped that those who deal, in hospital, social agency, or clinic, with handicapped persons—or in fact with any other members of "underprivileged minority groups" experiencing "overlapping" pulls toward two or more "situations"—may read this book for its wealth of information on research already accomplished and for its stimulus to further careful clinical and research observation.

RUTH M. HUBBARD.

Family Service Society of Metropolitan Detroit.

CLINICAL PSYCHOLOGY OF CHILDREN'S BEHAVIOR PROBLEMS. By C. M. Louttit. (Revised Edition.) New York: Harper and Brothers, 1947. 661 p.

Although advertised as a revised edition, this volume is essentially a reprinting, with very minor changes, of a volume of the same title originally published in 1936. It was and still is one of the best texts in the field of children's behavior problems. The point of view is eclectic, realistic, and practical, behavioral rather than Freudian, with a large emphasis on educational, sociological, and medical aspects and implications.

The content is organized in four parts: five chapters on diagnostic and therapeutic methods; four chapters on problems involving intelligence and special disabilities; four chapters on delinquency, speech, and conduct and personality problems; and two chapters on problems involving organic disabilities. There is a rich offering of case studies.

The original volume was noteworthy for scores of tables summariz-

ing a wide range of relevant statistical studies. The major limitation of the present volume is that, while the recent literature is cited in the bibliographies at the close of each chapter, these summaries of relevant data have not been brought up to date in the text.

FRANK K. SHUTTLEWORTH.
The College of the City of New York.

PSYCHOLOGY OF CHILDHOOD AND ADOLESCENCE. By Luella Cole and John J. B. Morgan. New York: Rinehart and Company, 1947. 416 p.

According to its preface, this text is intended for use in teachers' colleges and other colleges where it is desired to cover the psychology of childhood and adolescence in a single course. Perhaps the best way to review it is to give some idea of the contents of each chapter, reserving critical evaluations until this has been done. Such a method of reviewing the book should indicate what it covers and what it does not attempt to cover more fairly than a mere statement of the reviewer's opinion.

Chapter I, *Physical Growth,* gives facts about increases in height and weight, about skeletal development, and about the growth of various organs of the body (including the nervous system and endocrine system) from birth to maturity. Some of the implications of these data in terms of what should be expected of children in school at various stages of growth are mentioned.

Chapter II, *Motor Development,* summarizes studies of the preschool-age child's progress in mastering locomotor and manual skills, with a discussion of handedness included. There is also material on motor development in later childhood and adolescence. Practical suggestions are made to parents and teachers with regard to motor training.

Chapter III, *Emotional Growth,* begins by describing the physiological changes that accompany emotions, following with a fairly full account of the three major emotions — anger, fear, and love. The treatment of fear is largely from the viewpoint of ordinary fears or conditioned fear responses, however, without much comment on neurotic fears or phobias. There is a brief mention of the development of conscience and self-punitive tendencies during the middle years of childhood, but this topic is not elaborated either here or in later chapters.

Chapter IV, *Motivation,* is written largely from the viewpoint of the instinctive and emotional drives. There is some discussion of emotional conflicts resulting from disharmonies between these drives, but not of emotional conflicts arising from the opposing demands of the drives and the conscience. A large part of this chapter is practical, dealing

with the ways in which adults attempt to motivate children and with such questions as those of rewards and discipline.

Chapter V, *Social Growth,* reports studies of social behavior in early childhood and of the broadening of social development as the child grows beyond the pre-school age and finally reaches the stages of pre-adolescent and adolescent social activities. Again, as in other chapters, there is a consideration of the educational implications of the facts of social growth.

Chapter VI, *Homes for Children and Adolescents,* focuses on parent-child relationships and relationships between siblings, with stress on the kinds of parental attitudes that are favorable or unfavorable for the child's personality development.

Chapter VII, *Play and Interests,* reviews various theories of play and offers the definition that play is anything we do when free to do what we wish. The psychoanalytic theory is described as regarding play as a symbolic expression of wishes or feelings or as an effort at compensation. The further psychoanalytic view that play is often an attempt to master traumatic experiences, or work out some solution for emotional conflicts, is not mentioned, although there is a short discussion of "play therapy." Data from studies of play activities at various ages and of other interests—such as reading, attending movies, and so on — are reported.

Chapter VIII, *Intellectual Growth,* briefly describes intelligence tests for infants and school children and presents an excellent summary of the factors that may cause children to make lower ratings on such tests at one time than at another. The last part of the chapter deals with the development of different mental abilities, such as memory, reasoning, and imagination.

Chapter IX, *Bright and Dull Children,* considers deviations from the normal intellectual development described in the preceding chapter and the educational methods best adapted to superior and to mentally retarded children.

Chapter X, *Language,* tells how infants learn to talk by progressing from sounds to babbling and then to words, and gives data on growth of vocabulary, mastery of more complex language forms, and so forth. A section on speech defects and speech training is included.

Chapter XI, *Growth in Attitudes and Behavior,* summarizes studies of attitudes toward drinking, war, and racial minorities, and of the development of religious beliefs, honesty, and ideals. The emphasis is upon experimental and statistical investigations. Psychoanalytic contributions to our understanding of how attitudes and moral ideals are acquired are not included.

Chapter XII, *Personality,* discusses physiological factors and the influences of parental attitudes in the development of personality

traits, and describes significant behavior patterns. While there is a description of such patterns as regression, projection, and rationalization, there is no explanation of how these develop as defenses against anxiety and as a means of keeping emotional drives repressed. There is no account of the personality structure and its development as explained by psychoanalytic theories. Personality tests and scales are briefly described.

In the preface, Dr. Cole explains that the original plan for this book was a collaboration with Dr. Morgan, to combine into one volume the essential ideas of his *Child Psychology* and her own *Psychology of Adolescence,* but that Dr. Morgan's death left the entire responsibility for writing the present text upon her. She has certainly given an adequate summary of the experimental and statistical studies of child and adolescent development, but she has not drawn upon psychoanalytic and clinical viewpoints to the extent that Dr. Morgan usually did in his writings. Thus this presentation of childhood and adolescent development for the most part lacks the dynamic approach that was to be anticipated from the statement of joint authorship upon the title page. Some of the points at which the contributions of dynamic psychology might well have been introduced, but are conspicuously absent, have been noted above. It is difficult to understand why the utilization of such material was so restricted, for it could have been included without adding greatly to the number of pages and would have given the student a better understanding of the dynamics of emotional growth, personality development, and the motivations of behavior.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

PSYCHOLOGY, NORMAL AND ABNORMAL. By James W. Bridges. (Revised Edition.) Toronto, Canada: Sir Isaac Pitman and Sons, Ltd., 1946. 470 p.

This book is a revision of the text that first appeared in 1930. The topics are very similar to those in the original edition and the approach also bears a marked resemblance to the original. There is, however, some new material, and references are given to recent experimental investigations.

According to Professor Bridges, the book was written primarily as a textbook for introductory courses in psychology. From experience in teaching various courses in psychology, he has found that students get a better grasp of both normal and abnormal psychology when they are studied together. The justification for including material from the field of abnormal psychology in a text meant for a beginners' course, Bridges points out, is twofold.

First, the abnormal throws light on the normal, and the normal affords a basis for appraisal of the abnormal. Secondly, Bridges stresses, this approach arouses or increases interest in the subject, since many students have no great curiosity about ordinary human behavior. They are, however, interested in the unusual, the eccentric, the mentally defective, and the deranged.

The topics covered in this text are very similar to those included in all standard elementary texts. Bridges has, however, included several chapters not usually found in a textbook for beginners—namely, the chapters on sleep and dreams, psychopathology, play, work, fatigue, and applied psychology. Within each chapter, Bridges has presented first a description of the normal aspects of the mental process under consideration, and then a description of the abnormal development of the same process.

In spite of his avowed intention of trying to interest the beginner by presenting material that will have attention value, Bridges begins his text with topics that are likely to dampen students interest. Following the introductory chapter, which tells what psychology is, Chapter 2 launches into a description of some common statistical concepts in relation to a discussion of the meaning of "abnormal."

Chapter 3, the longest in the book, is entitled *The Mechanism of Behavior*. This chapter, as its name would suggest, gives a fairly detailed description of muscles, glands, sense organs, and the nervous system. After this somewhat dull and difficult introduction to psychology, the beginning student is then confronted with the theoretical question of what are consciousness and the unconscious and attention.

This arrangement of topics is, it seems, somewhat unfortunate. As the book progresses, it becomes easier for the beginner to understand and at the same time more interesting. This is due primarily to the fact that the topics are more concrete and more practical at the end of the book than at the beginning. A new arrangement of chapters would, in the reviewer's opinion, do much to increase readers' interest.

There is bibliography at the end of the book, and occasional direct references to texts or scientific journals are given as footnotes from time to time. Instead of grouping the references in the pattern of the textbook chapter outline, Bridges has grouped his according to subject matter. For a beginner, this grouping is apt to be confusing since his limited knowledge of the subject makes it difficult for him to know which book suggested in the bibliography is related to the topic in which he is primarily interested. Bridges does, however, give a one- or two-line description of the subject matter covered in each book listed.

As a general criticism, the outstanding weakness of this text, from the point of view of its use in American colleges and universities, is

its lack of an adequate number of direct references to experimental investigations. As one reads chapter after chapter, the general impression is that it is too theoretical and too abstract as compared with the accepted pattern of American textbooks in elementary psychology. In an effort to cover a very wide field, Bridges has made the mistake of being too superficial. The book is, however, readable and interesting in its method of presentation.

ELIZABETH B. HURLOCK.

New York City.

NEW FIELDS OF PSYCHIATRY. By David M. Levy, M.D. New York: W. W. Norton and Company, 1947. 171 p.

This book consists of the lectures delivered by Dr. Levy as the 1946 Salmon Memorial Lectures. They deal with Dr. Levy's recent work in political psychiatry, a new field born of America's democratizing efforts in the post-war world, as well as other areas of psychiatric influence. A valuable development in these new fields of psychiatry is the pioneer work done by the U. S. Information Control Division, which developed from the Office of Strategic Services in the early days of post-war Germany. Levy has prefaced a fascinating account of the utilization of psychiatry by politicians (in the true sense of practitioners of political economics) by a sketch of the induction of psychiatry into various social fields.

Deriving his material from his early experiences in child guidance and juvenile delinquency three decades ago, Dr. Levy, in an informative and readable manner, shows the extension of psychiatry into the field of child guidance, delinquency, industry, social service, and military work. The evolution of dynamic concepts in psychiatry into a practical body of knowledge, useful to workers who handle human problems elsewhere than in a mental hospital or a clinic, is an interesting piece of contemporary history. The statements advanced here are realistic and practical; the author makes no extravagant claims for psychiatry in social areas. This reviewer is familiar with the pitfalls to be avoided in trying to press dynamic concepts directly into the industrial plant, the courtroom, and even into military organizations, and quite agrees with the author that the psychiatrist's functions in social fields are not as yet fully formulated.

The last section of the book contains the pioneer work in politics of Levy and his associates. It originated from the screening techniques employed for the selection of officer material for the United States Army, which were extended to the screening of Nazis who wished to work in strategic positions under the American government in Germany. The methods, social, psychologic, and psychiatric, that

were used are outlined. There are interesting sections on the coördination of psychiatric study and political analysis, and a sample case study is given of a German publisher whose psychiatric analysis and whose answers to psychological questions were in accord with his political career under the Nazis and after. Various difficulties are stated, and the need for an over-all conjoined view of psychiatric, psychological, and political findings in estimating a personality in political action is well brought out.

This slim volume obviously is backed by much data not included in the lectures. It is also apparent that the pressing element of time, a common experience to every one who did psychiatric work in the war years, influenced the prosecution of the work. Nevertheless, Levy has arrestingly pointed to the value of psychiatry in estimating the social and political meaning of individual neuroses and the influence on men and events of neurotic characters in world history.

The book is recommended for every one with a forward-looking view of the place of psychiatry in the social sciences.

WALTER BROMBERG.

Reno, Nevada.

NOTES AND COMMENTS

1948 Lasker Award to Be Presented for Outstanding Accomplishment in the Education of the Physician in the Psychological Aspects of the Practice of Medicine

The 1948 Lasker Award of $1,000 for outstanding service in mental hygiene will be presented for a recent significant contribution to the education of the physician in the psychological aspects of the practice of medicine. (By "physician" is meant the non-psychiatric medical practitioner.) The work of the candidates for the award must have been accomplished or generally accepted during the past year or two. Presentation of the award will be made at the annual meeting of The National Committee for Mental Hygiene, to be held on November 3 and 4 in New York.

Any one may submit nominations, which should be forwarded by September 1 to The National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y. Further information will be supplied on request.

Conference on Mental Hygiene of the International Congress on Mental Health

The International Congress on Mental Health, which will be held in London, August 11–21 of this year, will consist of three international conferences: one on *Child Psychiatry,* with the general theme, Personality Development in Its Individual and Social Aspects with Special Reference to Aggression; one on *Medical Psychotherapy,* with the theme, Guilt; and one on *Mental Hygiene,* with the theme, Mental Health and World Citizenship. The first two conferences will run concurrently from August 11 to August 14; the third from August 16 to 21.

This third conference, which is sponsored by the International Committee for Mental Hygiene, will form the major part of the program. The following subdivisions of the general theme will be the main topics on consecutive days: (1) Problems of World Citizenship and Good Group Relations; (2) The Individual and Society; (3) Family Problems and Psychological Disturbance; (4) Planning for Mental Health: Organization, Training, Propaganda; (5) Mental Health in Industry and Industrial Relations; (6) concluding session and summaries.

Membership in this Conference on Mental Hygiene is open to trained workers in mental health and related subjects and to members of recognized organizations connected with such work. This includes applicants in the following categories: (1) members of professional associations in psychiatry, psychology, social work, sociology, anthropology; (2) members of the medical profession, the teaching profession (including nursery-school teachers), the nursing profession, and the clergy; (3) members of preparatory commissions working for the conference; and (4) individuals with special competence, special experience, or special interest in the field of mental hygiene.

Preparatory commissions, or discussion groups, are at work in many countries preparing material for the Conference on Mental Hygiene. Their reports will form the basis of much of the final program and will influence the choice of speakers in the plenary sessions. A monthly bulletin about this activity is issued from England.

The main topics have deliberately been widely drawn, leaving preparatory commissions and individuals freedom to select subsidiary topics (within the general framework) on which useful contributions can be made.

More than 1,000 interested persons from 47 countries have already indicated that they would be present. They will come from North and South America, Asia, Western Europe, and the Eastern European countries of Bulgaria, Roumania, Hungary, and Czechoslovakia. A total membership of at least 2,000 is expected, including an estimated 500 from the United States.

At present, 151 discussion groups are at work throughout the United States on various aspects of the conference's main topics. Their reports will be collated and integrated as the United States' contribution. Fifty additional groups are at work in other countries.

Two central commissions have been organized to coördinate and synthesize the reports of the preparatory commissions in the United States. One, the Central Commission on Children and War, of which Dr. David M. Levy is chairman and Miss Helen Speyer executive secretary, will deal with the work of commissions that have been studying various aspects of the general subject of the effect of war on children. The other—the Central Commission on Mental Health and World Citizenship—will work with the reports of the commissions that have studied topics outlined in the original conference program. Dr. Lyman Bryson is its chairman, and Lawrence K. Frank its executive secretary.

Three weeks before the congress, an International Preparatory Commission, made up of representatives from leading countries, is to meet, to prepare a comprehensive document, which will include recommendations based on the summaries of material furnished by the reports

from regional discussion groups in countries all over the world. These recommendations will be forwarded to the World Health Organization and U. N. E. S. C. O.

The tentative plans for the program of the Conference on Mental Hygiene are as follows:

In the mornings there will be plenary sessions, with two main speakers—one chosen from the International Preparatory Commission and the other chosen from a country at large because of his prominence in one of the professions represented at the congress. There will be two discussants and one individual to sum up, the latter to act as an alternate for either of the two main speakers if they have to drop out at the last minute. These five individuals for each of the five morning sessions, making 25 altogether, will be selected one only from each country, so that there may be as many countries as possible represented in the morning sessions.

The afternoon sessions will be mainly multi-professional, multinational small groups which will meet to discuss the document prepared by the International Preparatory Commission. These groups will be made up of 20 to 30 individuals, who will discuss certain items to be selected and announced in advance of the meetings. At least one member of the International Preparatory Commission will be present at each of these group meetings to act as a mediator and to explain how the International Preparatory Commission arrived at its conclusions.

In addition, there will be opportunity for meetings of professions, such as psychologists, sociologists, and so on. There will also be a number of small meetings, some of which may be organized by individual professions for the presentation of individual papers by persons who wish to present papers and have the competence to do so. Rooms will be assigned for these meetings and announcements of them will be made.

At the final plenary session, the document prepared by the International Preparatory Commission, copies of which will have been placed in the hands of every member of the Conference on Mental Hygiene, will be brought up for final adoption, with such changes as seem indicated. It has been planned to have a special committee working every night on modifications in this document as they come up in these meetings.

A twelve-member executive committee of the International Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y., is coördinating activities in the United States. Dr. Frank Fremont-Smith is chairman. All inquiries should be addressed to the executive officer, Dr. Nina Ridenour, from whom further information and application forms can be obtained. Travel arrangements are being

handled through the American Express Company. Since accommodations are limited, it is imperative that reservations be made immediately.

The International Congress on Mental Health presents a great opportunity for the attainment of a larger collective wisdom through the pooling of information and escape from the limitations of a too-narrow national or professional point of view. Dr. John R. Rees, of London, who was chief psychiatric consultant to the British Army, is president of the congress. It has the support of U. N. E. S. C. O. and the World Health Organization of the United Nations. It is proposed to form a continuing organization out of the congress to be known as the World Federation for Mental Health. This would become the official voluntary consultative agency in the field of mental health for U. N. E. S. C. O. and the World Health Organization.

Financial support to the amount of $100,000.00 has been received in contributions from private companies and foundations both here and in Britain. Further funds are urgently needed to carry through a congress of this scope and magnitude and a campaign has been started to raise an additional $150,000 in this country. Contributions from individuals or groups will be most gratefully received. Suggestions as to possible sources of contributions would also be most welcome.

First Recipient of Psychiatric Aide of the Year Award

Walter Starnes, a psychiatric aide at the Winter Veterans Administration Hospital, Topeka, Kansas, was named the first recipient of the Psychiatric Aide of the Year Award presented by the National Mental Health Foundation, of Philadelphia.

The award was established last year as part of the foundation's campaign to encourage the adoption of higher standards of care in mental hospitals. In recognition of his outstanding service, Mr. Starnes is receiving $500 and a citation.

Five candidates who were cited for honorable mention are each receiving $50 awards. They are: Miss Elizabeth Johnson, Ypsilanti State Hospital, Ypsilanti, Michigan; Dee Fletcher, Veterans Administration Hospital, North Little Rock, Arkansas; Mrs. Viola M. Griffith, St. Elizabeths Hospital, Washington, D. C.; William Finn, Veterans Administration Hospital, Northampton, Massachusetts; and Roy Kimberling, Middletown State Hospital, Middletown, N. Y.

The successful candidate was selected by a board of judges prominent for their interest in the field of mental health. Serving on this panel were Dr. Robert H. Felix, Medical Director and Chief of the Mental Hygiene Division of the United States Public Health Service;

Albert Deutsch, journalist; Mary Jane Ward, author of *The Snake Pit*; Mrs. Ruth P. Kuehn, Dean, University of Pittsburgh School of Nursing; Dr. Robert Sutherland, Director, The Hogg Foundation for Mental Hygiene; and Miss June Joslyn, Executive Director, the Oregon Society for Mental Hygiene.

Nominees for the award were selected from among more than 12,000 psychiatric aides by the medical and nursing staffs and patients in private, Veterans Administration, and other public mental hospitals throughout the country.

According to the nominating statement made on his behalf, Walter Starnes is a tall, slender, friendly-appearing Negro, in his early forties. He was born and reared in Topeka, Kansas. He received his elementary schooling in Topeka and moved with his family to Washington, D. C., at the age of fourteen. There he finished high school, but his college career was cut short in the hectic '30's because of financial difficulties. After this disappointing experience, he was variously employed as a bell-hop, waiter, janitor, and elevator operator until 1942, when he was inducted into the army. In the military service, Mr. Starnes's latent capabilities for assuming responsibility came to light and he rapidly rose in rank to technical sergeant in the transportation corps. Subsequent to his discharge, he learned of the need for psychiatric aides at Winter Veterans Administration Hospital, and made application for this position. In April, 1946, he began work and five months later he was made charge aide on a closed ward. Since that time, he has been moved to more and more responsible positions.

Commenting on the selection of Walter Starnes as the first recipient of the award, Dr. Karl A. Menninger, Manager of Winter Veterans Administration Hospital, stated:

> "In modern life we have grown used to annual awards for the outstanding people in almost all fields of endeavor. These range from the much coveted Nobel Prize, for men outstanding in the arts and sciences, to the 'Oscars' of the film industry which further the notoriety of already well known people. Now, for the first time, comes a prize that makes known an unknown man from an almost unknown group. As Walter Starnes is chosen 'The Psychiatric Aide of the Year,' few are the people who will even know what a psychiatric aide is.
>
> "The National Mental Health Foundation, in initiating its yearly award for the outstanding psychiatric aide, is calling the attention of the public to a group of people whose service is rendered far away from the public eye and whose excellence can only be judged as one judges the excellence of one's own friends. The psychiatric aide is, in the last analysis, the friend and companion of the mentally ill. By day and by night he is our ambassador from the 'normal' world.
>
> "Walter Starnes, then, is an ambassador extraordinary. The qualities for which he was chosen—kindness, tact, sensitivity to the needs and feel-

> ings of others (many of them inarticulate), patience, humility, and, above all, character—could very well make Starnes the outstanding man of the year.
>
> "Many will commend the National Mental Health Foundation for initiating this contest and in this we heartily join. That this honor has been given one of our aides is one of the most gratifying things that has ever happened to us at Winter Veterans Administration Hospital."

Program of Institutional Service Units in Wisconsin

A project patterned after the Institutional Service Units started during the war by the American Friends Service Committee was instituted last year in Wisconsin by the Committee for Improved Care of the Mentally Ill, affiliated with the Wisconsin Welfare Council, in coöperation with the Division of Mental Hygiene of the State Department of Health. One of the purposes of the project is the same as that of the American Friends service units—to meet critical personnel shortages in state mental and correctional institutions—but the Wisconsin program has been expanded to fulfill a broad public-education function. Its purposes, as set forth in a recent report on the project, include:

> "1. Arousing greater public interest in the acute personnel needs of state mental institutions.
>
> "2. Showing the citizen his responsibility to the mentally ill and mentally deficient when they return to the community.
>
> "3. Giving participants a first-hand knowledge of social problems related to mental illness and mental deficiency.
>
> "4. Encouraging higher standards of service for attendants and matrons as well as in-service training for institutional workers.
>
> "5. Providing an opportunity for a broadening experience which develops personalities and makes for more alert citizens and active leaders in their future professions."

The first Wisconsin unit was organized in the summer of 1947 and served at the Southern Colony and Training School for mentally deficient at Union Grove, Wisconsin. It consisted of twelve members—four from Milwaukee State Teachers College, five from Beloit College, one from the University of Wisconsin, one from Nashota House, and one from Cornell University, Ithaca, New York—ranging in age from nineteen to thirty. Other such units throughout the country have had members of from eighteen to thirty-five. Although eighteen is considered rather young for this type of work, experience has shown that some mature eighteen-year-old people have done exceptionally fine work. The members of the first Wisconsin unit represented the fields of teaching, sociology, social work, theology, and law.

All of the students were interviewed after their arrival at the Southern Colony by the supervisor of psychiatric social work for the

state division of mental hygiene, to learn their special skills and interests. On the basis of these counseling interviews, suggestions were given to the institution superintendent on possible assignments of the unit members.

The unit set up its own system of self-government, electing an "assistant director," who served as chairman, a secretary, and a treasurer, and appointing committees on education, recreation, and publicity. With the advice of project advisers, the unit planned and arranged a series of twelve lectures, on subjects connected with various aspects of institutional work.

Unit members worked a regular work shift of eight hours a day, six days a week, receiving the minimum wage for attendants, less maintenance and a contribution toward the unit-project budget. The excellent coöperation of the institution superintendent and staff was particularly important to the success of the unit. For most unit members, work in an institution is very different from anything they have ever done before. There are menial and tedious chores to be done, and many adjustments to be made. A constructive and coöperative attitude on the part of the regular staff and administration of the institution is, therefore, essential to the success of the project.

Other unit activities, besides work on the wards and their own educational program, consisted of supervision of playground activities, and extra-hour recreational activities for the patients. Each Saturday evening a picnic was held either for boys or for girls in groups of from 20 to 36. Several community sings also were held, with 150 to 200 patients in attendance. These were such a success that the administration plans to continue them. Another activity that turned out well was a party given by the students for the regular attendants and staff.

As a result of the success of the first Wisconsin unit, it is now planned to set up an 18-member unit in the summer of 1948 either at the Mendota State Mental Hospital or the Winnebago State Mental Hospital, as well as another 18-member unit at the Southern Colony and Training School. All three institutions need attendants, assistant occupational therapists, recreation leaders, and nurses.

Service-unit students will receive minimum prevailing wages for attendants. At the present time this amounts to $134 per month, from which $25 is deducted for maintenance. Unit members also contribute $10 to $18, depending on their length of service, payable in monthly installments, to the budget of the Institutional Service Units.

It is planned to have the 1948 summer units begin on June 15, 1948. Members may not enroll for less than eight weeks. Application blanks will be available from the State Division of Mental Hygiene, State Capitol, Madison, Wisconsin. However, since enrollment in the proposed units must necessarily be limited, college faculty and depart-

ment heads interested in offering this opportunity to their students are urged to write first to Mrs. Hans Wendel, Chairman, Sub-Committee on Institutional Service Units, 3240-A South Illinois Avenue, Milwaukee 7, Wisconsin, for further information about the project, and to report tentatively on the number of their students who may be interested in enrolling in one of the proposed units. On the basis of this preliminary information, colleges and universities will be advised of the number of students from each school that can be accommodated by the project.

Arrangements will be made for a preliminary screen of prospective applicants either on the basis of information submitted in writing or by personal interviews at the respective colleges and universities. Such screening is highly desirable from the point of view both of the student and of the success of the project. Although training and experience in a specific field are assets in an applicant, they are not required.

Prospective student applicants who wish to correspond with members of the 1947 summer unit about their unit experiences will be given that opportunity if they wish to write in for names of former unit members.

The prospective applicant is advised to ask himself or herself the following questions and to be guided by the answers:

"Should you join an I.S.U.?

"Yes—if you:

"Are willing to give much more than you receive;

"Are physically strong and emotionally stable;

"Have a strong desire to know and work with people with love and understanding in your heart;

"Feel a responsibility to participate in the working unit so that it will be most effective in helping the patients and residents as well as embracing other regular employees of the institution;

"Realize the need of a spiritual approach to our everyday living and working with others;

"Have an interest in our state institutions—their need of help in personnel and interpretation that you as an alert citizen or future professional person may do in your community;

"Wish to learn and participate in the series of courses set up for the unit during the summer.

"No—if you:

"Are primarily interested in earning some money;

"Cannot work under physical and emotional strain or dislike disagreeable work;

"Do not feel that you can work and play with a group—adjusting to rigid schedules for work and meals, the authority which older employees exert as a result of their experience, restraint rules, the humble position of attendants, and the inability of the unit to change the institution in one day—or one summer—or for years;

"Are not self-disciplined in everyday habits—of eating, sleeping, etc.;

"Do not have resources within yourself to find pleasure and recreation while working in a location away from the usual 'manufactured' forms of recreation, as movies, concerts, dances, etc."

The sponsors of Institutional Service Units believe that the project offers a rare educational opportunity to young people to learn by the work-and-study method and to serve society at the same time.

Group for the Advancement of Psychiatry Issues Report on Preventive Psychiatry

The report below was formulated by the Committee on Preventive Psychiatry of the Group for the Advancement of Psychiatry and approved by the membership.

"*The Field of Preventive Psychiatry.*—Preventive psychiatry has not as yet been developed as a separate discipline in the field of psychiatry, although the need for such a development has been a pressing one and is now imperative. A beginning in this direction can be made if, instead of attempting a definition, the problem is stated in terms of 'what are the goals of preventive psychiatry?' This question may be answered as follows: The goals of preventive psychiatry are the promotion of mental health and the prevention of emotional and mental disturbances through education, motivational techniques, and modification of environmental factors, including cultural values. This does not mean merely early treatment, but is conceived of as going far beyond such a point. Efforts to attain these goals would be directed in their operation toward the average of the population.

"*How to Approach These Goals.*—The first step should be a compilation and a critical review of available data pertinent to the field. From this, a body of positive data will be on hand for immediate application, and any serious gaps in the body of knowledge will become apparent. This will enable planning and the encouragement of research projects and the activation of the use of the data already at hand as a means of prevention.

"It is necessary to consider man's behavior from two standpoints: (1) the infant is a growing organism, motivated by various developmental forces which operate throughout the life cycle; (2) to enable the individual to develop properly, to become integrated with the group, and to live out his life cycle, there must be provided the appropriate external conditions in terms of those physical, psychological, educational, and emotional forces that bear upon man during his lifetime. This includes the effect of cultural factors *per se* not only upon the individual, but also upon the group.

"Examples of area of interest for study in terms of goals of preventive psychiatry as stated above are: (1) pre-natal development; (2) parent-child relationships; (3) adolescent relationships; (4) adult problems at home and at work and in other interpersonal relationships; (5) problems of the aged; (6) constitutional factors.

"*Techniques of Approach.*—The most effective way of reaching these goals is by using methods applicable to groups as distinguished from those effective for individuals. This may be called the epidemiological

approach. It is in effect the approach used in the field of preventive medicine. The procedure in general is to ascertain the areas of unduly high incidence of ill health in the community in terms of economic, geographic, or social areas; to seek out the causes of the high incidence of ill health in these areas; and then to use basic knowledge available in medicine to attempt to remove these causes. In the field of preventive psychiatry where mental health is the primary concern, these and other principles and practices from the field of epidemiology and public health are applicable.

"Some of the techniques which have proved useful in preventive medicine and which are recommended for application in preventive psychiatry are as follows:

"1. Education: Educational measures would be directed to individuals and groups to increase their ability to adjust to external and internal stress. Such efforts must be thought of as long-term projects and effects must not be looked for immediately. Examples are: adequate instruction in the psychology of behavior to school-teachers, college students, and medical students.

"2. Motivational techniques: These techniques are to be distinguished from education in that attempts are made to motivate people to specific, appropriate action through various media of communication (press, radio, movies, literature). An example of this is a campaign undertaken (in the sense that advertising campaigns usually are) to induce the public to take as much action as possible to alleviate the distressing and deplorable conditions in overcrowded state mental hospitals and specifically to urge their representatives to appropriate funds for proper maintenance of state mental institutions.

"3. Modification of environmental factors, including cultural values: A third technique is to attempt to change environmental factors, such as bringing about the removal of undue stresses or introducing supportive measures through influencing the individuals or groups in authority, such as industrial leaders, labor leaders, legislators, church leaders, school superintendents, school boards, etc., to see the need for such changes and the benefits which will accrue from them. An example would be better training and selection of school-teachers, better salaries for school-teachers.

"Psychiatrists should learn how these techniques are employed and help with their application. Special attention should be paid to those cultural forces which promote and those which are inimical to mental health. There are at present few psychiatrists who are active in what this Committee conceives to be the field of preventive psychiatry. This Committee recommends that G. A. P. [Group for the Advancement of Psychiatry] actively interest itself in getting competent psychiatrists to enter this new field. The Committee on Preventive Psychiatry of the American Psychiatric Association is attempting to do this.

"*The Priorities of Areas for This Committee.*—The immediate projects are oriented around the general area of child-parent relationships. Available data are being critically reviewed by members of the Committee in terms of studies made by workers in the fields of psychology, education, sociology, cultural anthropology, and psychiatry. This will be initiated by gathering a selective bibliography pertinent to preventive psychiatry from these five fields. When this has been done, the material will be integrated and through the methods described above, attempts will be made to apply them in prevention."

Psychotic First Admissions to Mental Hospitals—1940–1945

A Census Bureau report by Henry D. Sheldon and Alan B. Crammatte on psychotic first admissions to mental hospitals during the war years, 1940–1945, shows a rise in the rate of such admissions, especially marked among males of military age. To quote the report:

> "For all patients with psychosis, the estimated number of first admissions to hospitals for the permanent care of psychiatric patients increased from 71.7 per 100,000 of the population in 1940 to 86.8 in 1945, an increase of approximately 21 per cent. In the same period, however, the age-specific rate for males 20 to 24 years old more than doubled; and the corresponding rates for the age groups, 25 to 29 years and 30 to 34 years, increased by 78 and 36 per cent, respectively. The estimates are only for first admissions with psychosis. The figures do not cover first admissions with psychoneuroses nor those diagnosed as with marginal disorders, such as simple alcoholism, mental deficiency, or drug addiction, which, in the American Psychiatric Association classification, are designated as 'without mental disorder.'
>
> "That there is some connection bteween the induction of millions of young men into military service and the increasing first-admission rates among males 20 to 34 years old, is evident. As indicated above, there were striking increases in first-admission rates for males in those age groups which contributed most heavily to the armed forces. These marked increases appear to be unique to the period under consideration. Figures available for 1922, which are reasonably comparable to those presented here, indicate, for males 20 to 34 years old, an increase of roughly 1,000, or 10 per cent, between 1922 and 1940 as compared with the estimated increase between 1940 and 1945 of 10,137, or about 82 per cent. The increase in this group for veterans' hospitals between 1940 and 1945, 13,050, not only accounted for the over-all increase during the period, but also compensated for the decreases which occurred among admissions to other types of hospitals. This shift was, of course, to be expected; and the contrast between veterans' and other types of hospitals would have been greater had not appreciable numbers of veterans of World War II been admitted to state, county, and private hospitals. Finally, it should be noted that the figures presented here understate to some slight degree the true admission rates among young males, since they do not cover patients who were discharged directly from hospitals operated by the armed forces and not subsequently admitted to veterans' hospitals. It is not clear whether this increase in psychotic first-admission rates among young males reflects the psychological hazards of military life or whether it reflects the fact that at no time in our history has such a large group of persons been subjected to such intensive psychiatric scrutiny under conditions calculated to high-light abnormal behavior.
>
> "For males in each of the 5-year age groups between 40 and 64 years, there appears to have been a slight decrease in first-admission rates. The decreases were not large and, in general, were greater between the years 1941 and 1944 than they were for the entire period. On the average, however, the rates for each age group were higher in the first three years of the period than they were in the last three years. It seems probable that these decreases reflect the effects of the war-time man-power shortage. Certainly, the increased sense of economic security and personal worth,

which grew out of the sharp demand for the services of men in the middle years of life, and the widely publicized and often repeated emphasis on the importance of their contribution to the war effort, were calculated to contribute appreciably to the mental and emotional stability of this segment of the population.

"For males 70 years and over, the first admission rate increased from 303.7 in 1940 to 390.6 in 1944 and then decreased to 372.6 in 1945. Since there is a good deal of variability in the amount of care required by psychiatric patients in this age group, it does not seem unreasonable that variations in the frequency with which they are committed to institutions may reflect variations in the facility with which they can be cared for in private households. If this analysis is correct, the increased mobility, the housing shortage, and other dislocations of family life incident to the war-time situation may well explain to some degree the increase in first-admission rates for elderly males.

"Differences in trends among the female age-specific first-admission rates were much less marked than the corresponding rates for males. Among females, the rates for each quinquennial age group showed an increase between 1940 and 1945. The general pattern of increase, however, resembled somewhat that for males in that the largest percentage increases in the age-specific rates occurred among females under 40 years of age and among those 65 years old and over, whereas the smallest increase occurred in the middle years of life. The greatest increase—from 229.6 in 1940 to 333.6 in 1944 with a slight decrease to 323.3 in 1945—occurred among females 70 years old and over and is subject to the same interpretation as the corresponding increase among males."

U. S. Public Health Service Takes Over Census of Patients in Mental Institutions

The annual census of patients in mental institutions, which has been conducted by the Bureau of the Census since 1926, has been transferred to the Mental Hygiene Division of the United States Public Health Service, as a result of its increased responsibilities under the National Mental Health Act. An institutional statistics unit has been established in the Statistics and Special Studies Section, of which Dr. Charles C. Limberg is acting chief. Dr. Henry D. Sheldon, who has been chief of the Institutional Statistics Unit of the Bureau of the Census, will continue to be chief of the unit upon its transfer.

In addition to continuing the census of patients in mental hospitals and institutions for epileptics and the mentally defective, plans are now being made to enlarge the census of psychopathic hospitals and psychiatric services in general hospitals, and to include a census of mental-hygiene clinics operated under federal, state, and local government and fraternal and private auspices. Publication of the consolidated annual report, *Patients in Mental Institutions*, will be continued by the Public Health Service.

World Report on Venereal Diseases Stresses Post-War Danger

World-wide increases in the venereal diseases reported during war time continue unabated into the post-war period, according to a report published in the February issue of the *Journal of Social Hygiene* by the American Social Hygiene Association.

The report, unique for its comprehensive coverage and statistical detail, calls new attention to the virtually universal threat to public health arising from the prevalence of venereal diseases, and notes that this threat is intensified by the present-day speed and scope of population movements between countries. A special feature is the assembly by continents and countries of all available statistics on venereal-disease incidence and prevalence, brought together in a single document for the first time in many years.

Prepared by Thorstein Guthe, M.D., formerly of the Norwegian Health Service, now World Health Organization Medical Officer at Geneva, and John C. Hume, M.D., of Johns Hopkins University School of Hygiene and Public Health, with the collaboration of other experts, and approved for publication by the U. S. Army and the U. S. Public Health Service, the report asserts that war intensifies venereal-disease problems not only during the period of actual conflict, but later as well, adding:

"After the war, venereal diseases still remained a public-health problem in all countries, and the impact of military occupation and demobilization has reflected itself in venereal-disease rates even higher than those observed during the war."

Among major facts disclosed by the report are the following:

1. Judged by "conservative" estimates, from two to four million newly acquired cases of syphilis at a minimum occur annually in the world's population, and from six to twelve million new cases of gonorrhea. Judged by the same conservative yardstick, syphilis prevalence on a world scale is estimated at certainly no less than 20,000,000 cases.

2. While increases still continue in many parts of the world, a "leveling off" is seen in the venereal-disease incidence rates in the United States and western Europe.

3. Data gathered on a world scale give new evidence of the close relationship between living standards and social conditions on the one hand and venereal disease prevalence on the other. A study of conditions in the U. S. Zone of Germany, showing a correspondence between the rise in venereal-disease incidence and the decline in the weights of civilians, high-lights these findings.

The report proposes a whole series of recommendations for national and international action to strengthen efforts for venereal-disease

control. These include proposals for uniform reporting procedures on a world scale; international use of national control measures; the establishment of administrative, scientific, and procedural standards, within the framework of a uniform plan to be worked out by the World Health Organization, the International Union against the Venereal Diseases, and other governmental and non-governmental agencies concerned.

Reprints of the report, which is being distributed internationally by the World Health Organization, may be obtained in the United States from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y., at a price of 40 cents; 50 cents if mailed outside the United States. Ask for Publication No. A-713, *International Aspects of the Venereal Disease Problem.*

Workshop on Family Life Education

A workshop on family-life education is being held at the University of Chicago, August 2 through September 3, 1948, for selected leaders currently active in school and community programs of education for family living. Evelyn Millis Duvall, Executive Secretary of the National Council on Family Relations, is director of the workshop, and also shares seminar leadership with Ernest W. Burgess and Robert J. Havighurst, of the University of Chicago. Among the lecturers who have been invited to participate are Drs. Alfred Kinsey, William Menninger, Leland Stott, Ralph Tyler, and Alvin Zander. Further information may be secured from the Workshop Secretary, University of Chicago, Chicago 37, Illinois.

A Summer Workshop in Counseling

A summer workshop in counseling will be held at Goddard College, Plainfield, Vermont, July 5 to August 14, 1948. The workshop is restricted to professional workers in the counseling fields who will study common problems and practices. The areas of study will include: psychological counseling, theory and practice; evaluation of current counseling techniques; seminar on techniques; personality diagnosis; introduction to the Rorschach; advanced seminar in the Rorschach; projective methods; vocational testing and diagnosis; and vocational counseling.

The workshop is under the direction of Dr. Peter Blos, clinical psychologist, New York City. Consultants include: Drs. Arthur W. Combs, University of Syracuse; Clements C. Fry, Yale University; Elizabeth Kundert, state psychiatrist, Vermont; W. Mason Mathews, Merrill-Palmer School; Ruth L. Monroe, Sarah Lawrence College;

Fritz Redl, Wayne University; Otto Spranger, New York University; Frederick Wyatt, McLean Hospital.

For further information write to Goddard College, Plainfield, Vermont.

Annual Convention of the American Occupational Therapy Association

The Thirty-First Annual Convention of the American Occupational Therapy Association will be held at the Hotel Pennsylvania, New York City, September 7–11. The program will consist of open meetings, round tables, field trips, and a two-day institute.

Fellowships Offered by American Association of Psychiatric Clinics for Children

The American Association of Psychiatric Clinics for Children offers fellowships for training in child-guidance-clinic psychiatry under the auspices of the United States Public Health Service, the Commonwealth Fund, and some local funds. The training is for positions in community clinics in which psychiatrists, psychologists, social workers, and others collaborate in the treatment of children suffering from emotional or mental illness.

Most of the fellowships are for two years; some for one. The stipend is $3,000 for the first year, and more for the second. Prerequisites are graduation from an approved medical school, a general interneship, and two years of general psychiatry.

Opportunity is provided for the fellow to develop his own skills in a well-organized out-patient service with the support of a carefully planned training program and adequate supervision. The training centers are selected on the basis of standards that have been established by the American Association of Psychiatric Clinics for Children, and the fellowships are awarded by a committee of this organization.

For further information write to Dr. A. Z. Barhash, Executive Assistant, The American Association of Psychiatric Clinics for Children, 1790 Broadway, New York 19, N. Y.

Federal Grants for Training Mental-Health Personnel

Announcement has been made of the award of further federal grants for training mental-health personnel under the National Mental Health Act.[1] These grants go to universities, hospitals, and clinics to support their training programs in the field of psychiatry, clinical psy-

[1] For a list of grants previously made, see Mental Hygiene, Vol. 31, pp. 674–75, October, 1947.

chology, and psychiatric social work. The grants were recommended by the National Advisory Mental Health Council and approved by the Surgeon General.

The institutions that are receiving the present grants are:

Psychiatry

University of Pennsylvania, Philadelphia, Pa.
*The Menninger Foundation, Topeka, Kansas
Boston Psychopathic Hospital, Boston, Mass.
University of Cincinnati, Cincinnati, Ohio
Institute of Psychoanalysis, Chicago, Ill.

Clinical Psychology

*University of Kentucky, Lexington, Ky.
*Tulane University, New Orleans, La.

Psychiatric Social Work

Washington University, St. Louis, Mo.

* Training stipends to graduate students in psychiatry, clinical psychology, and psychiatric social work will be administered by all these institutions, except those marked with an asterisk. All stipends have been awarded except at Washington University. Information on these may be obtained by writing directly to the university.

News of Mental-Hygiene Societies

California

Dr. G. Eleanor Kimble, Executive Secretary of the Mental Hygiene Society of Northern California, is acting as an area coördinator for the Conference on Mental Hygiene of the International Congress on Mental Health. She reports that in her area of Northern California, thirteen preparatory commissions have filed applications for official recognition.

Connecticut

The Connecticut Society for Mental Hygiene reports on a busy and interesting three months. During December, the Waterbury Chapter held two very successful meetings, at which Dr. Evelyn Millis Duvall, Executive Secretary of the National Council on Family Relations, addressed adults and teen-agers. The explanation of the enthusiastic response of the teen-age group to Dr. Duvall's lecture, is her key-note theme: *"How Do You Get a Date and What Do You Do With It When You Get It?"*

The Fourth Annual Campaign for Christmas Gifts for patients in mental hospitals in Connecticut was a conspicuous success. Plans were set up to continue the work of the Christmas Gifts volunteers on a year-round basis through an activity committee. This committee will collect and distribute in the state's mental hospitals gifts of magazines and books, games, athletic equipment, musical instruments,

victrola records, needlework materials, and so on, and will help with library service and recreational leadership.

On January 30 the New Haven membership committee of the society arranged a meeting at which Dr. Lawrence S. Kubie, recently appointed clinical professor in psychiatry and mental hygiene in the Yale School of Medicine, spoke on "The Future of Preventive Psychiatry." The meeting was open to the public, and an audience of 600—some driving from as far north as Hartford, forty miles away—crowded Yale University's Sterling Law Auditorium.

On February 18, Miss Frances Hartshorne, Executive Secretary of the Connecticut Society for Mental Hygiene, on a busman's holiday in the South, spoke in Miami, Florida, before a meeting of the Mental Health Society of Southeastern Florida, on "The Program of a Mental Hygiene Society." On her way back to Connecticut, Miss Hartshorne stopped off in Columbia, S. C., to speak on "What the Connecticut Society for Mental Hygiene Is Doing" before a meeting of the South Carolina Mental Hygiene Society held in conjunction with the Southern Regional Conference of the Child Welfare League of America on February 19–21.

Florida

The Mental Health Society of Southeastern Florida has opened an office at 700 S. W. 12th Avenue, Miami 36. The society has as yet no permanent staff. Until the required funds can be secured, Mrs. Frances J. Riordan, of Miami, is acting as executive secretary. The officers of the society are: President, Chester M. Wright, Miami; First Vice President, Garland M. Budd, Miami; Second Vice President, Mrs. Warren W. Quillian, Coral Gables; Secretary, Mrs. Charles Enterline, Miami; and Treasurer, Mrs. Sidney Weintraub, Miami Beach.

At a general meeting of the society held on February 18, the guest speaker was Miss Frances Hartshorne, Executive Secretary of the Connecticut Society for Mental Hygiene, who told of some of the interesting projects launched by the Connecticut Society.

Hawaii

During the first week of February the Mental Hygiene Society of the Territory of Hawaii held a Mental Health Week which was most successful.

The governor issued a proclamation designating February 2 to 7 as Mental Health Week and copies of his proclamation were used in some of the store windows as part of a display. One of the insurance

companies that has display windows on a busy street devoted their entire display space to mental-hygiene pamphlets and used the proclamation with dramatic effect. Many of the stores coöperated in various ways, not only in having window displays, but in setting aside tables in their book departments with current literature on mental hygiene and some of the society's pamphlets and reading lists.

The first day of the week was devoted to the Parent-Teacher Association. Some of the local associations had speakers on mental hygiene; others used the records, *Meet Your Mind;* and the day closed with a skit put on by the Child Guidance Clinic of the Bureau of Mental Hygiene under the board of health. This skit, which dramatized an interview at the clinic, was called *Stormy Weather,* and was an original production written by members of the staff and enacted by them, with the addition of a child actor to play the part of the "problem child."

The next two days were devoted to visiting the territorial institutions—the boys' and girls' training schools, the school for the feeble-minded, and the penitentiary. Many people visited during this time and excellent coöperation was received from the churches and social agencies, particularly the Y. W. C. A. and the Y. M. C. A.

On Thursday the society held its annual meeting. The speaker was the medical director of the territorial hospital, who gave an excellent paper on psychosomatic medicine. About 150 people attended the meeting.

On Friday, the territorial hospital was open to the public for general visiting, and in the morning the staff demonstrated various types of treatment and held a clinic for professional people—doctors, nurses, and social workers. This particular part of the program was attended by over 200 professional people.

During the week the society also initiated the two radio programs it is sponsoring—*The Tenth Man* and *The Inquiring Parent.* In addition, the Oahu Health Council wrote a special script which told something about the purposes of the society in a dramatic form, and one of the local news commentators devoted a considerable portion of his program to the society and its work.

The newspapers were most generous in the amount of space donated, one of them giving editorial space for a series of articles during the week.

The society reports further that a commission has been formed to prepare material for the International Conference on Mental Hygiene this summer, which one of the members of the organization plans to attend. The topic chosen for discussion is "Changing Aspects of Aggression in One Race—the Japanese."

Illinois

The Illinois Society for Mental Hygiene, in coöperation with other agencies, such as the Chicago Council of Social Agencies and the Illinois Psychiatric Society, has been active in offering consultation both to the state department of public health and to the Chicago Board of Health in the administration of funds received by the state under the National Mental Health Act. So far two cities have been granted allocations, to be made through the local health-department units: Rockford, Illinois, is to receive $10,000 for the operation of a mental-hygiene clinic in coöperation with the state veterans rehabilitation center; and Chicago has been allocated approximately $50,000. The city council has approved the creation of a division of mental health within the department of health and has authorized the expenditure of a salary for the administrator of this division. According to present plans, during the first year the major effort in this division will be an educational program within the department itself.

Stimulated by the successful campaign of 1947 for the improvement of the care of the mentally ill in state hospitals, the society plans to carry on a campaign for the extension and the creation of new mental-hygiene facilities for children in Illinois.

The educational committee of the society has been charged with the responsibility of exploring the possibilities of the society, placing its major educational emphasis upon the orientation of professional groups in mental hygiene, both on a pre-service and an in-service basis. To begin with, the professions of nursing and teaching will be explored with this objective in mind.

A revision of the Directory of Psychiatric Facilities in Illinois has just been published by the society, and a revised pamphlet list is also available for distribution.

Maryland

The Mental Hygiene Society of Maryland announces that Mr. Edward H. Yaggy, who was chairman of the Planning Committee on Non-Clinical Activities of the society, has been elected president of the society. Mr. Yaggy recently rendered an outstanding report of his committee's activities and recommendations, and he now has the opportunity to see this program through.

Since September, 1947, the psychiatric clinic of the society has conducted an evening clinic for the psychiatric treatment of adults. This clinic is part of a broad training program. Ten psychiatrists who are in training, six of them at a state hospital, are engaged in psychotherapy under careful supervision. Two well-qualified psychiatrists volunteer one evening a week to assist the clinical director

in supervising the treatment. A psychiatric social worker is assigned to assist in the work of the clinic, which meets one evening a week. Twenty-one patients are continuously under treatment. Already the results, in terms of profit both to patients and to doctors in training, are very gratifying.

Nevada

The Nevada State Mental Hygiene Society has been interesting itself in the commitment laws and procedures operative in the state. The last few meetings have been devoted to understanding the history of the insanity law as it evolved from statutes and the organic law of the state. Anachronisms have been noted in the law and the society hopes to present recommendations to the state legislature in its next meeting in 1949 to remove these. A recent act of the legislature improved the insanity law by supplanting the term "mentally ill" for "insanity," but further clarification seems necessary.

Oklahoma

Reverend W. H. Alexander was reëlected president of the Oklahoma Committee for Mental Hygiene at its annual business meeting in Oklahoma City on January 13. Other officers elected were: First Vice President, Mrs. T. G. Gibson, of Ardmore; Second Vice President, Welcome D. Pierson, of Oklahoma City; Treasurer, Charles L. Leopold, of Oklahoma City; and Chairman of the Executive Committee, Merton Bulla, of Oklahoma City.

In anticipation of an intensive membership campaign, the Oklahoma Committee has added a field worker to its staff—James Logan, of the Social Work Department of the University of Oklahoma. Mr. Logan assumed his duties in February.

Oregon

The Oregon Mental Hygiene Society reports that it is broadcasting the radio series, *The Tenth Man,* over nine stations, with much interest expressed and many inquiries.

In February, in coöperation with the E. B. Brown Trust, Division of Social Hygiene, University of Oregon Medical School, the society sponsored a lecture series on "The Emotional Health of the Family Group," which was well attended.

During the past year a study was made of facilities for the detention of the mentally ill, pending commitment, in each of the 36 counties of the state. It was found that in most of the counties there is no place available except the jail, and despite the ingenuity of sheriffs and judges, jails often have to be used.

The matter was brought to the attention of the state board of health, which was setting up standards for new hospitals, with the result that the following paragraph appears in the "Rules, Regulations and Standard for Hospitals," recently adopted by that board:

> "MENTAL UNIT. In the case of all General Hospitals constructed after these regulations are promulgated, provision shall be made for a mental unit, consisting of an adequate number of sound-proofed rooms with adequate safeguards for the patients, and in the case of all other General Hospitals such facilities should be provided at their earliest convenience."

Eventually this will do away with detention in jail, though it will be a long-time program.

Pennsylvania

The Public Charities Association of Pennsylvania is a state-wide citizens' organization which includes mental hygiene among its several functions. Recently, in order to strengthen both the public-health and the mental-hygiene functions, plans were made to divide the Mental Hygiene and Public Health Division into two separate committees. The new position of secretary of the Public Health Division was filled by Miss Louisa J. Eskridge, formerly consultant in public-health education with the United States Public Health Service; and Mr. Ross W. Sanderson, Jr., who had already been serving on the association's staff, became secretary of the Mental Hygiene Division. The chairmen of the Mental Hygiene Division are Dr. Frederick Allen, of Philadelphia, and Dr. James Henninger, of Pittsburgh.

After careful discussion by its mental-hygiene division and its executive committee, the association has urged the State Department of Welfare of Pennsylvania to accept the funds available to it under the National Mental Health Act for use in strengthening community services throughout the state. This action was taken after Pennsylvania had failed to take advantage of some $195,000 which would have been available to it during the current fiscal year.

South Carolina

The South Carolina Mental Hygiene Society reports that a clinic with a full-time psychiatric social worker, a part-time psychiatrist and psychologist, and a clerical staff has opened in Spartanburg under the National Mental Health Act.

On February 20, a large group from the society heard Miss Frances Hartshorne, Executive Secretary of the Connecticut Society for Mental Hygiene, at a luncheon in Columbia.

Texas

Dr. Ozro T. Woods, of Dallas, President of the Texas Society for Mental Hygiene, has recently appointed committees to coöperate with the Committee on Mental Hygiene of the Texas State Medical Association to secure more professional supervision in the state hospitals for tuberculosis and mental illness, and with the Texas State Teachers Association to explore methods whereby local public-school systems may be made more mental-hygiene conscious.

Students of two state colleges at Denton have organized an Intercollegiate Society for Mental Hygiene. Interest in these organizations continues to grow.

Virginia

The Eleventh Annual Meeting of the Mental Hygiene Society of Virginia was held in Richmond, February 19. The general theme of the meeting was "Hostility." Dr. J. Franklin Robinson, of Richmond, spoke on "The Hostility in Childhood"; Dr. C. Spurgeon English, of Philadelphia, on "The Effect of Hostility on the Human Organism"; Dr. Julius Schreiber, of Washington, on "Hostility in Inter-Group Relationships"; and Honorable Herbert Cochran, of the Juvenile and Domestic Relations Court, Norfolk, Virginia, on "Hostility, Its International Implications."

The society reports the formation of three new committees during the year—on membership, education and publicity, and reviewing; also the organization of five new chapters—in Charlotte County, Newport News, Lynchburg, Norfolk, and Portsmouth—bringing the total up to nine.

One of the society's main interests has been the establishment in the state of a good community mental-hygiene-clinic program. With federal funds made available under the National Mental Health Act and additional funds contributed by local communities, more than $200,000 will be spent this year for this purpose.

Wisconsin

The January issue of *Mental Health*, the quarterly journal of the Wisconsin Society for Mental Health, is largely devoted to material that may be used by community groups in programs on mental health. Of special interest is the article by Senator Gustave Buchen—*Sixty-two Questions and Answers on the 1947 State Mental Health Act.* Senator Buchen was chairman of the committee of the state legislature that drafted the act and saw it through to successful passage. He prepared the article at the request of the Wisconsin Society in the belief that if the act is to be effective, the people of the state must

know what was intended and must learn how to support the officials who administer it. As part of its educational work, the society is sending reprints of the article to the committing judges and district attorneys of the state, with an appropriate letter.

Dr. Daniel Blain Named Medical Director of American Psychiatric Association

Dr. Daniel Blain, formerly Chief of Neuropsychiatric Services for the Veterans Administration, has accepted the newly established position of Medical Director of the American Psychiatric Association. The position has been created to provide the full-time services of a medical man who will act for the association as an authorized source of information and advice.

As medical director, Dr. Blain will make his services available to the membership, to affiliate societies, and to public and private organizations interested in the field of psychiatry. Activating policies approved by the association, and stimulating appropriate groups and committees to respond to needs and demands, he will serve also to effect liaison with the public on subjects relative to the work of the association and to the general interests of society.

Dr. Blain will continue to reside in Washington. For the present, he may be addressed at the Georgetown University Hospital, Washington, D. C., or at the executive office of the association, Room 924, 9 Rockefeller Plaza, New York City 20. Eventually he will have a permanent office in Washington. Mr. Austin M. Davies who has been with the association for the past fifteen years, will continue as executive secretary, with headquarters in the New York office.

Dr. Tompkins to Head Veterans Administration's Neuropsychiatric Division

Dr. Harvey J. Tompkins has been appointed head of the neuropsychiatric service in the Veterans Administration Department of Medicine and Surgery, succeeding Dr. Daniel Blain, who has resigned to accept the position of medical director of the American Psychiatric Association.

Dr. Tompkins, a native of Chicago, obtained his education at Loyola University, Chicago, receiving his B.S. degree in 1929 and his M.D. in 1932. He interned at Mercy Hospital, Chicago.

In 1935 he joined the Veterans Administration and has been assigned to hospitals at Danville, Illinois; Mendota, Wisconsin; St. Cloud, Minnesota; and Knoxville, Iowa. While at the Mendota hospital, working in coöperation with the University of Wisconsin medical staff, Dr. Tompkins established a highly-successful diagnostic and

intensive-treatment center for the care of veterans suffering from mental or nervous disorders. Since 1945 he has been assigned to the central office of the Veterans Administration in Washington, as assistant chief of the neuropsychiatry division and chief of the inpatient (hospital) section.

Dr. Tompkins is a member of the American Psychiatric Association, of the Association of Military Surgeons, and of the Group for Advancement of Psychiatry. He is associate professor in psychiatry at Georgetown University School of Medicine, and is certified by the American Board of Psychiatry and Neurology.

Recent Publications

A new *Directory of Psychiatric Clinics in the United States* is expected off the press in early May. This is the eighth edition of such directories. The resources listed are as follows: (1) the state mental-health authorities through which federal grants-in-aid are received; (2) the state mental-hospital authority; (3) the state mental institutions; (4) federal mental institutions, especially Veterans Administration and U. S. Public Health Service Hospitals; (5) mental-hygiene societies; (6) clinics. The clinic data will include the name, address, auspices, staff, name of chief psychiatrist, hours of service, and number of cases handled.

The last directory that gave such complete detail was completed and edited by The National Committee for Mental Hygiene and published by the Commonwealth Fund in 1932. It comprised 166 pages. It is believed that the number of clinics has more than doubled since that time and that this new unabridged directory will fill a long-felt need.

That excellent little booklet by Dr. George K. Pratt, *Your Mind and You,* which presents in a popular manner the scientific aspects of mental health, is again available through The National Committee for Mental Hygiene. The price is 35 cents. Discounts on quantities are as follows: 100—499 copies, 20 per cent; 500 or more copies, 33⅓ per cent.

The Division of Personnel Placement of The National Committee for Mental Hygiene has made available a compilation of the training programs for clinical psychologists. The demand from students for information concerning interneships and externeships in clinical psychology had become so great that, after consultation with leaders in this field, it was decided last October to circulate a questionnaire to those clinics listed in the *Directory of Psychiatric Clinics in the United States,* in order to learn of existing programs.

Approximately 50 clinics—child guidance, mental hygiene, and psychiatric, in communities, universities, and state and private mental hospitals—are represented in the compilation. The material is presented exactly as submitted on the questionnaire; no attempt has been made to classify the replies and we share no responsibility to the applicant for the fulfillment of these training programs. However, it is believed that the compilation will serve a worth-while purpose in guiding students, and also may prove to be an aid to advisers in colleges and universities who are called upon to assist students in finding training centers.

The compilation may be obtained from The National Committee for Mental Hygiene, at a price of 50 cents a copy.

The *Baltimore Health News*, published by the Baltimore City Health Department, devotes its January–February issue to a mental-hygiene outline and guide for public-health nurses in the field of maternal and pre-school-child health. The outline deals with basic considerations, suggestions for interviewing, the expectant mother, the infant from birth to twelve months, and the pre-school child. It is designed, according to the introduction, "to provide information to the clinic physician and to serve as an aid to the public-health nurse in using mental hygiene as a component part of her maternal and child-health work. It is not designed for use without prior orientation nor for the purpose of direct parental education. It consists of suggested material to be used with judgment and flexibility." The outline was prepared for use in a program of preventive mental hygiene instituted by the City Health Department in October, 1947.

A series of four pamphlets on speech and hearing problems in children is being sponsored by the Cleveland Junior Chamber of Commerce of Cleveland, Ohio, in coöperation with the Cleveland Hearing and Speech Center, whose staff prepared the material contained in the pamphlets. The first of these—*A Child Doesn't Talk*, by Amy Bishop Chapin and Margaret Corcoran—is now available. The other three—*A Child Stutters, A Child With a Cleft Palate*, and *A Child Doesn't Hear*—are scheduled for future publications.

A Child Doesn't Talk discusses such questions as: "When should you worry?" "How should you feel about him?" "Why hasn't he learned to talk?" "Will school help him learn to speak?" "How can you help him at home?"

For copies of the pamphlet, write the Cleveland Junior Chamber of Commerce, 400 Union Commerce Building, Cleveland 14. Price: 25 cents for a single copy; 16 cents each in lots of 25 or more.

The United States Public Health Service is preparing a new series of publications on mental health. The first of these, a folder entitled, *For Mental Health,* describes briefly the program planned under the National Mental Health Act and offers suggestions as to how the public can coöperate in it. Single copies may be obtained free of charge by writing to the Chief, Public Health Section, U. S. Public Health Service, Federal Security Agency, Washington 25, D. C.

Evidence that "planned" children are both healthier and happier than the average is presented in the 32-page pamphlet, *Planning Your Family,* by Herbert Yahraes, recently issued by the Public Affairs Committee, of New York City.

Mr. Yahraes makes it clear that "planned parenthood" does not mean "control" in the sense of restraint or check, but "power of direction" in the sense of spacing children so that they will come when the mother is physically and emotionally well and the family able to provide for them, and in the sense, also, of assisting childless couples to become parents.

He points out that "hundreds of thousands of women in the United States are using birth control who should be having babies—not only for the future welfare of their country, but (if they but knew it) for their own future happiness."

In contrast, a recent Indianapolis survey is cited showing that among couples who *planned* their families, the most children were born to the parents on the highest income-and-education level.

The pamphlet notes that a wide gap exists between the public need of child-spacing services and the available sources of information. To close this gap, it recommends: (1) the adequate teaching of birth-control techniques in all medical schools—plus the teaching that these techniques ought to be used not only to save a woman's life, but also to guard her health and that of her family; (2) the establishment of child-spacing clinics as part of the obstetrical and gynecological divisions of every hospital, so that a woman who has just had a child can learn without going elsewhere how to have her next child at the best possible time; and (3) the inclusion of planned-parenthood services in every state, county, and community public-health service.

Planning Your Family is Pamphlet No. 137 in the series of popular, factual, 20-cent pamphlets issued by the Public Affairs Committee, at 22 East 38th Street, New York 16, N. Y.

The Western Personnel Institute of Pasadena, California, has prepared a booklet for college students on vocational opportunities in the fields of psychology, psychiatry, and psychiatric social work. It discusses briefly the general nature of each of these fields, the types

of job available in each, requirements in the way of training and experience, and salaries. The booklet, *Opportunities for Psychologists, Psychiatrists, Psychiatric Social Workers,* can be obtained for $1.00 from the Western Personnel Institute, 30 North Raymond Avenue, Pasadena 1, California.

A bibliography on the individualized treatment of the offender has been prepared by the Russell Sage Foundation Library at the request of the Division of Probation of the New York State Department of Correction and in collaboration with Charles S. Antolina, Probation Examiner. The list is intended primarily for use in connection with the Manual for Probation Officers in New York State, but it is hoped that all workers in the field of correction will find it helpful. The bibliography, which was compiled by Allan H. Wagner, Assistant Reference Librarian, can be obtained at a price of 20 cents from the Russell Sage Foundation Library, 130 E. 22nd Street, New York 10, N. Y.

WANTED: COPIES OF JANUARY, 1948, MENTAL HYGIENE

The National Committee for Mental Hygiene would greatly appreciate it if any subscriber who does not care to keep his copy of the January, 1948, issue of MENTAL HYGIENE would return it to this office, Room 916, 1790 Broadway, New York 19, N. Y. The edition has been exhausted and we are receiving requests for copies.

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EVA R. HAWKINS
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